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## ORIGINAL ARTICLES.

### SUBCUTANEOUS DIVISION OF URETHRAL STRICTURE.<sup>1</sup>

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ORGANIC urethral stricture becomes sometimes so difficult and so obstinate an affection to treat that we are forced to resort to other than the usual methods for its relief. Such being the case, it is not surprising to find that, from the earliest times, dangerous and difficult operations have been introduced for its cure, or rather for its immediate relief: among which are incisions made from the outside, through the integument and urethral wall, dividing all the diseased structures, and leaving the parts gradually to reunite. Such operations may all be embraced in the one general term "External Urethrotomy."

As far back as we have any recorded history of surgery, we find the ancient surgeons, like ourselves, encountering difficulties in the treatment of urethral stricture, and oftentimes unable to gain an entrance into the bladder through the natural channel. Hence, they were forced to resort to the use of the knife, by which incisions were made into and through the urethral walls. Celsus was evidently familiar with such an operation, for in Book vii., Chapter xxvi. of his writings, we find this passage:

"In suppression of urine, if the urethra is stopped by a stone, the prepuce must be drawn out as much as possible, and the glans being covered, it must be tied by a thread; then, on one side, a longitudinal incision must be made into the penis, and after this the prepuce is let go; for by this means the sound part of the skin covers the incision in the penis, and the urine will be discharged in the natural way."

It is very evident that he certainly intended to speak of *retention*, and not *suppression* of urine, and that the incision was made in the urethra and not into the body of the penis. A natural inference to be drawn from this quotation is that, if Celsus advised opening the urethra to get rid of an impacted stone which was obstructing the flow of urine, he evidently would have advised a similar operation in a case of retention caused by any other obstruction, as, for example, stricture of the canal. Still later than the time of Celsus, we read in the writings of Rhazes in the tenth century, a clear description of such an operation having been done for obstruction of the urethra. Again, Avicenna, who wrote in the eleventh century, mentions puncture of the urethra through the perineum for the relief of retention of urine. These operations appear to have been intended solely to give exit to retained urine, but with

no intention or proposed plan of curing the disease which caused or produced the obstruction; the object of the ancients being more the relief of the immediate symptoms than an endeavor to eradicate the disease.

The first reliable mention of an operation of which we have any positive knowledge, which was performed for the cure of stricture, and not entirely for the relief of retention, is the one recorded by Richard Wiseman, in his work entitled *The Ill Consequences of Gonorrhœa*. Here he speaks of having witnessed, in the year 1652, an operation done by Mr. Edward Molins, "which," says Wiseman, "consisted of an incision into the urethra near the neck of the bladder, for retention of urine; that the knife did not readily divide it, for it was as hard as a gristle; the urethra being opened, the urine gushed out, and the wound remained fistulous." In this operation, if we fully understand Wiseman's description, the incision was made into the urethra posterior to the obstruction, and subsequently the incision was carried through the coarctation to its anterior face, a very similar operation to the "boutonnière," a proceeding of which we shall have occasion to speak more at length in the course of this paper.

Again, in the latter part of the same century, we find Soligen performing similar operations, once at Livourne, and again at the Hague. Then we hear of an operation, which was designated "la boutonnière," being done in 1687 by François Tolet, for the relief of retention, but not for the cure of stricture; and he tells us that it was an operation much in vogue "by men of great skill and reputation," and employed by them only in cases of great emergency.

Then, François Colot follows him, operating in 1690 for the cure of impassable stricture complicated with perineal and scrotal fistulæ. From that date onward we find, scattered here and there through the early literature of the profession, only references to the subject, until the year 1730, when Ledran operated upon "a case of organic impassable stricture;" this operation he did at two sittings, and after the following manner: The first day, the perineum was opened down to the urethra, and on the succeeding day he opened into the canal upon the anterior face of the stricture, through which, after gradual dilatation for five days, he passed a bougie on into the bladder; when this had been accomplished, he "slit up the urethra as far as the neck of the bladder." Gradual dilatation was then resorted to, by which the entire length of the urethra was stretched open, and the patient is said to have gotten well.

About the same date, J. L. Petit, on numerous occasions, appears to have performed similar operations for retention of urine, and in some cases he divided the stricture at the same time, with the evident in-

<sup>1</sup> Read before the American Surgical Association, May, 1886.

tention of curing the obstruction. Petit relates a case where he performed the operation for the cure of a stricture through which it was impossible to pass an instrument, although there was no retention of urine, and no fistulæ through which urine could find its way. He cut through the urethra at the face of the stricture, upon a grooved sound introduced down the canal to the seat of obstruction, after which he forced a trocar through the obstruction and into the bladder, following the supposed course of the urethra. He then slit up with a bistoury the strictured portion, tied in a catheter, and left the wound to heal by granulation, which it did in about a month or longer time, and the patient is reported as having been entirely cured. This was probably the first case in which a "sonde à demeure," or retained catheter, was ever used. Petit subsequently resorted to a similar operation in a number of cases, and states that, whenever he has performed "la boutonnière" (as he termed it) for retention of urine, his patients always "regained the freedom of the canal when he comprehended the obstacle itself in the incision." But he is very careful to remark that "la boutonnière is to be shunned whenever the introduction of a sound is practicable."

In 1750, twenty years after the operations of Ledran, Mr. Sharp, of England, described an operation very similar to his, "by cutting in *perineo* if possible upon a staff," and recommended its performance; but, in 1782, we find him condemning it in no measured terms, and advocating in its stead the suprapubic operation for relief of retained urine, as one less to be feared, and less serious in its results.<sup>1</sup> Only six years after this date—*i. e.*, in 1788—John Hunter comes to the front, and not only advises but urges the operation as the proper one for the cure of strictures complicated with perineal fistulæ; he himself having performed, in 1783, an operation in which he cut upon a staff introduced down to the stricture, and exposed the face of the obstruction, which was subsequently dilated so that the staff was with difficulty passed on into the bladder. This was neither new nor original with Hunter, for in the year 1738 both Astruc and Daran had described the operation as done by Hunter, and again in 1748 called the attention of surgeons to the method; but they both opposed and advised against its performance. In 1786 both Chopart and Desault performed the operation in various ways, but the mortality proved so great, and they denounced it in such violent terms that very few surgeons could be found who were willing to attempt it. Desault writes:

"The operation known under the name of 'la boutonnière,' though apparently better adapted to the nature of the disease, is, almost always, either useless or dangerous. It is useless if the surgeon has been able to pass a grooved director for the purpose of operating, because in such a case he might just as well introduce a hollow sound. It is dangerous if the surgeon has no director to guide him, for then he makes his incisions at hazard, may miss the canal, and divide parts, the lesion of which is followed by more or less serious accidents."

Chopart having had no success with the operation, became bitter in his denunciations of the procedure; and the failures, together with the great mortality attending it, about the close of the last century, threw it into such disrepute, that very few surgeons could be induced to perform it. Mr. Sharp, of England, then condemned it, and very soon it fell into disuse in France, and was not again practised in England until about the year 1807, at which time Sir Charles Bell called attention to it as an operation peculiarly adapted to, and required in those cases of aggravated stricture of the urethra complicated by perineal fistulæ: still the operation did not receive favor in England, and we hear little or nothing more of it until the year 1817, when it was revived and introduced into America by the late Dr. Alexander H. Stevens, of New York, who then operated successfully upon a case of stricture by this method after all other means of relief had failed. Then Dr. Jameson, of Baltimore, began to operate in 1820, and by the end of the year 1823 he had performed ten operations without a single death. This remarkable success with a hitherto unsuccessful operation naturally directed the attention of American surgeons to the method, and it was not long before it became popular in New York and other Eastern cities. Dr. D. S. Rogers, of New York, also began the operation in 1823, and very soon laid before the profession the report of twelve operations, all successful. By the year 1843 Warren, of Boston, March, of Albany, Hoffman, Post, Watson, and Buck, of New York, with many other American surgeons, had, by large numbers of successful cases, all done without the use of a conductor, so fully established the propriety of the operation, that it at once became an accepted operation on this side of the Atlantic.

Carefully examining the reports of these cases, we find they were all performed after the method of the "old boutonnière," that is to say, without a conductor, which goes to prove they were cases impassable to instruments. So, before we investigate the subject further, it may not be out of place to show what is meant by that term, and then analyze the methods which come under that general description.

This operation has been performed in so many ways that we are at a loss to understand the exact idea which the old authors wished to convey when they used the term "la boutonnière." The most explicit description which we have been able to find, is the one given by Desault in his treatise upon the diseases of the urinary organs; this is, to my mind, most clearly evident that the operation was performed in three ways: *First*, upon a conducting staff which was passed through the stricture and on into the bladder, upon the groove of which conductor the incision was made. *Secondly*, where a staff was passed down the urethra until it reached the anterior face of the stricture, and the urethra opened upon the point of the staff, after which the stricture, together with the integuments, were all laid open by the knife upon a director which was introduced through the stricture from its distal opening. *Thirdly*, a staff was passed down to the stricture, and the urethra opened in the membranous portion posterior

<sup>1</sup> "A Critical Inquiry," London, 1850.

<sup>2</sup> A Treatise on the Operations of Surgery, etc., by Samuel Sharpe, F.R.S., etc. Tenth edition. London, 1782. Chapter xv. pages 77, 78.

to the obstruction, through which opening a grooved director was passed *from the posterior face* of the obstruction forward through the stricture until it came in contact, or nearly so, with the end of the staff as it rested upon the anterior face of the coarctation; then a knife was pushed along the groove of the director from behind forward, and the entire stricture, together with wall of urethra and integuments, all ripped open: this last method is the one usual with French surgeons. This completes a running epitome of the operation from its early history, to the year 1849, when Mr. Syme, of Edinburgh, called the attention of the profession to "A New Operation for the Cure of Urethral Stricture:" a method which he had devised, and which consisted in passing a special staff through the stricture, then opening the urethra behind the coarctation, upon the small grooved director attached to the staff; in this groove he passed a sharp, narrow-bladed knife forward through stricture, integuments, and all, laying the urethra freely open. It is, however, scarcely necessary to consume time by a long description of the method of the Scotch surgeon, or a detail of his cases, for I presume all are perfectly familiar with it.

It may not be uninteresting, however, to show what were the conclusions which he proposed to draw from his method; and it will serve my purpose better if I quote his own language on this point—they are as follows:

"1st. That there is no stricture truly impermeable, and that, with time and care in every case, an instrument may be passed through it, and serve as a guide for the knife.

"2d. That all strictures which cannot be remedied by simple dilatation, admit of effectual relief only through a free division of the contracted part of the canal.

"3d. That this object can be obtained with certainty and safety only by an external incision in a line corresponding with the raphe of the perineum upon a grooved director passed through the stricture.

"4th. That the only after-treatment required is the introduction of a catheter during forty-eight hours, with the subsequent use of a full-sized bougie at distant intervals.

"5th. That the operation, if properly performed, is free from any risk whatever of hemorrhage, extravasation of urine, or fistulous opening."

I shall examine these conclusions and see how far they may be fully received; whether or not, in the first place, the proceeding is entitled to be considered "a new operation;" how far, if in any particular, it differs from one of the varieties of "la boutonnière;" and, more important than all, whether it is free from danger. That it is not a new operation has been clearly proved by the description of the boutonnière by Desault. In his first division, he shows that the staff was passed through the stricture and the coarctation cut upon the groove of the same; in his third division, that the urethra was opened posterior to the contraction, just as Mr. Syme described it, a director passed from behind forward, and the stricture cut from its posterior to its anterior boundary. The director of Desault was passed from behind, whilst that of Mr. Syme was introduced from the front; this is the

non-essential difference in the two operations, one of no consequence, since the stricture, integuments and all, were laid open and left to granulate after both operations.

Mr. Syme has assumed the non-existence of impermeable stricture, and says:

"There is nothing of more consequence in the treatment of stricture than the knowledge of the fact that this alleged impermeability has no real existence except in those cases where the urethra has been divided by violence and allowed to cicatrize with obliteration of the passage beyond the opening at the seat of injury. It is obvious, indeed, that if the urine is permitted to pass, no matter how small a stream, or even by drops there must be room for the introduction of the instrument, if it be sufficiently small and properly guided."

Even this assertion is not new, since Mr. Liston had, in 1835, enunciated the same opinion, as shown by this language—"there are no strictures impassable that I have ever seen, for where any water comes away, you can, by patience and perseverance, get a catheter through sooner or later." Still these assertions have not been proved, since we find in Mr. Syme's own work two instances in which he acknowledges that he was unable to pass his special staff, and consequently he was forced to open the urethra anterior to the stricture and then cut through the same, as in Desault's description of his second division of *la boutonnière*. Mr. Liston also has been repeatedly foiled in his attempts to introduce a catheter through an ordinary stricture, and was obliged to have recourse to an operation of tapping the bladder both above the pubis and also through the rectum. Yet Mr. Syme asserts that he has never been called upon to perform his operation for impermeable stricture, and simply because he had never met such a case. He makes permeability an indispensable prerequisite to the performance of external division, and does so upon the ground of the "*danger, uncertainty, and difficulty*" which, he asserts, must attend all operations done in the perineum in search of the urethra, without a guide. His own assertions are conclusive evidence that there are impermeable strictures, even if we had no better authority; but upon this point the united experience of almost all surgeons goes to show and to prove that there are cases of stricture oftentimes met with which are impassable to instruments yet not absolutely impermeable to urine.

2. His second conclusion is far from being sustained, since there are too many well-attested cures of resilient stricture—strictures which have proved rebellious to dilatation—which have been thoroughly relieved and permanently cured by the simpler operation of internal urethrotomy; thus sustaining the well-established fact that when a stricture is not impassable to instruments, external division is contraindicated.

3. If we can rely upon the testimony of Mr. Lizars—and his assertions have not been refuted—Mr. Syme's own cases were not with certainty and safety relieved. Mr. Lizars conclusively showed that the statements of Mr. Syme were not to be relied upon, since his cases had not been fairly or even correctly reported by himself, and that a large num-



ber of his operations proved failures, since in many instances the patients were placed in a most terrible condition as the result of his method: profuse hemorrhage occurring in quite a number of them, and also extravasation of urine followed by extensive sloughing, terminating in numerous fistulæ. Mr. Syme himself acknowledges the dangers of the operation when he writes, giving the history of some "eighty or ninety cases," that "alarming symptoms were by no means rare, since every third or fourth patient suffered from rigors, vomiting, delirium, or suppression of urine." Besides these troubles, he met with two fatal cases which he attributed to contact of the urine with the wound.

It is not the purpose of this paper to cast the least reflection upon the distinguished surgeon whose name has been so intimately associated with this operation, nor to condemn the operation of external section. I am writing its history, and desire simply to give the result of my investigations, and show what objections are sustained against it. It is certainly proved, that from the most remote times it has been considered a dangerous and difficult operation, and even in our own day, when surrounded by all the appliances of improved surgery, and encouraged by the success which has attended it, some of the best modern authorities pronounce it an operation not free from danger, but one which requires the most consummate skill for its successful execution.

The venerable, gifted, and distinguished founder of this Association, a man who made, and has left his impress indelibly stamped upon the surgery of the nineteenth century, used this forcible language when writing of the operation:

"The operation is by no means free from danger and requires the most consummate skill for its successful execution. None but a madman or a fool would attempt it unless he had the most profound knowledge of the anatomy of the parts, and a thorough acquaintance with the use of instruments. Of all operations of surgery, this is the least to be coveted."<sup>1</sup>

The operation has not been fully accepted in France, and was rejected by a commission of the French Academy which was appointed to sit in judgment upon it. Civiale, than whom no sounder authority in matters pertaining to genito-urinary surgery has lived, himself never performed it, although he was known frequently to have had resort to the old operation of "la boutonnière."

With all the objections brought to bear upon the various operations of external section, still we are, as I before stated, sometimes called upon to relieve a patient from retention of urine, caused by obstinate and impassable or impermeable stricture: and when that rare contingency does arise, and when milder measures have utterly failed, the urethra remaining absolutely impervious,—letting in no catheter, letting out no urine—then undoubtedly this condition will establish a necessity, a legitimate and imperative and urgent necessity, for our making an arti-

ficial vent for the discharge of the contents of the distended bladder.

This brings me to the consideration of the indications which render such an operation necessary.

*Indications.*—1st. The impossibility of passing a sound into the bladder through the urethral canal, when a firm organic contraction blocks up the urethra and proves rebellious to either dilatation or internal urethrotomy. Here we are imperatively called upon to relieve an over-distended bladder, else we find cystitis being developed, bladder walls becoming hypertrophied, ureters dilated, and kidneys disorganized. The nervous system, overwhelmed by the absorption of urea, cerebral symptoms speedily ensue, and the patient dies comatose. In such cases, the constitutional distress is urgent, and the demand for relief imperative; it then becomes dangerous to temporize with milder methods, and as a rational but *dernier ressort* we must perform an external section. But even in such cases it is not always necessary to do an operation through the perineum, or from without inward; for in some cases it is possible to cut down through the axis of the urethra into and through the stricture, although it may be impassable to the smallest instrument. Of this I speak advisedly, since I have myself done such an operation upon several occasions where I was not willing to subject the patients to the gravity of an external section. It is true the operations were exceedingly difficult, yet they were completed with perfect safety and relief to the patients.<sup>1</sup>

2d. Infiltration of urine resulting in abscess may necessitate an external section. I do not here refer to those sudden cases where from direct injury the urethra has been ruptured and infiltration is the consequence, but I allude to those cases where a tight stricture has existed for a length of time; where a periurethral abscess has resulted from a small opening in the urethra behind the stricture, and the gradual infiltration of urine has lighted up inflammation to a degree sufficient to form a circumscribed deposit of pus. In such cases it is necessary to open the abscess for the purpose of relieving the sufferings of the patient. To do this more effectually, it will be well to carry the incision still deeper, and lay open the urethra at the site of rupture, then carry the knife forward through the stricture to the point of a sound introduced down to the anterior face of the coarctation.

3d. The third indication *might* be placed where certain cases of old tight strictures complicated with urinary fistulæ through which a great part of the urine escapes at every act of micturition.

Many surgeons contend that here is a clear and unmistakable indication for an external section, but, unless in some exceptional cases, I cannot give my unqualified assent to the proposition, since experience has clearly shown that in almost all cases of urethral fistula, so soon as the lumen of the canal is fully restored, the fistula heals; and very soon thereafter, when the normal calibre of the urethra has become established, the innodular tissue which sur-

<sup>1</sup> Lancet, Aug. 21, 1858, p. 191.

<sup>2</sup> S. D. Gross, *Diseases, Injuries, and Malformations of Urinary Organs*. Second edition, 1855, page 801.

<sup>1</sup> For report of cases, see Richmond and Louisville Medical Journal, Sept. 1873, vol. xvi. page 285.



rounds the fistulous opening becomes absorbed. Such being true, I prefer an internal section as less dangerous and equally efficacious.

4th. The most important indication which may arise, is when the urethra has been ruptured by a violent blow, and when the effects of such injury are rapid and severe. In some of these cases serious results do not take place immediately after the injury; but in others, enormous extravasation of blood may occur immediately upon the reception of the injury—then retention takes place, and the whole cellular tissue becomes infiltrated with urine.

In such cases the operation of external section becomes an absolute necessity, not only for the purpose of evacuating extravasated blood and infiltrated urine, but for the immediate purpose of getting a catheter into the bladder; for it becomes an almost impossible matter to introduce an instrument *per vias naturales* when the urethra has been lacerated. If, however, a free incision is made through the perineum upon the point of a large sound, first passed carefully down the canal to the point of injury, then the sound can be carried into the bladder and the patient placed in comparative safety.

5th. Traumatic stricture—that is, where a stricture has been formed as the result of a direct injury done to the urethra; for example, where fractures of the pelvis have injured the urethra and blocked up with a dense deposit the perineal and ischio-rectal regions. It is very well known how intractable such strictures prove, and how difficult, in many cases, it is to introduce an instrument of even the smallest size into and through such constrictions. In these cases ordinary dilatation proves inefficient, and internal urethrotomy is often of little or no avail. Here, then, we have an evident and clear indication for external section, as the speediest method by which we can gain access to the bladder.

6th. A calculus impacted in the urethra behind a stricture, if large, may be an indication for opening the urethral canal. In some of these cases it is very difficult and oftentimes impossible to thread even the smallest filiform guide through the stricture for the purpose of conducting the staff of an internal urethrotome. In such cases, when an imperative necessity exists for the evacuation of an over-distended bladder, we have only the alternative of aspiration or external section remaining, and of the two, external section seems preferable, and should be done, thus removing the calculus and at the same time opening the stricture by an incision directed from behind forward through the coarctation. Even here an exception

ingenious instrument for this purpose, which this distinguished surgeon presented to the French Academy for its consideration in 1871.

7th. The next indication is when extravasation of urine has occurred from sudden rupture of the urethra, and in a short time extensive sloughing has taken place from infiltration of urine into the loose tissue of perineum, penis, scrotum, and groins. Here is an absolute necessity for making free incisions for the purpose of evacuating necrotic tissue together with pus and urine. In these cases it is well, if possible, to open the urethra at the site of stricture, so as to admit of the introduction of a catheter into the bladder. This is, however, not always possible when we come to consider the disorganized condition of the parts. In such cases nothing is left the surgeon save to meet the emergencies as they may arise.

8th. The last indication, if I may term it such, is the one in which Mr. Reginald Harrison advocates the combined operation of internal and external section. He advocates doing an external section immediately following an internal operation, and then keeping the bladder emptied through a large elastic drainage tube carried from the external opening into the bladder, and retained until the internal urethrotomy has healed. His reasons for this are, that patients, in his hands, have usually suffered from urethral fever after the first passage of urine, and that they do not have that trouble until the incision has been bathed by the urine in its passage along the canal. To avoid this complication, he advises doing the external section and draining the bladder. As it would necessarily increase the length of this paper for me to enter into a long detail of his special views upon this subject, I shall now close the indications for the operation by calling the attention of those who desire to know more of his paper to *The British Medical Journal*, of July 18, 1885.

In a given case, where an operation has been decided upon, the question arises as to what form of operation offers the best prospects of success, and which, under the circumstances, can be done with most ease to the surgeon. As for myself, I have found the operation as recommended by Mr. Syme, not only difficult to perform, but unsatisfactory in its results. An established maxim with surgeons has been that "a stricture being permeable to instruments, an external division is contraindicated." Mr. Syme, on the other hand, has reversed this, and made *permeability* an indispensable prerequisite to the performance of an external section. To this I

FIG. 1.



may arise should the calculus be small, in which event it is best to open the face of the stricture through the axis of the urethra, so as to expose the calculus, which can then be broken up and removed by the urethral brise-pierre of Reliquet (Fig. 1), an

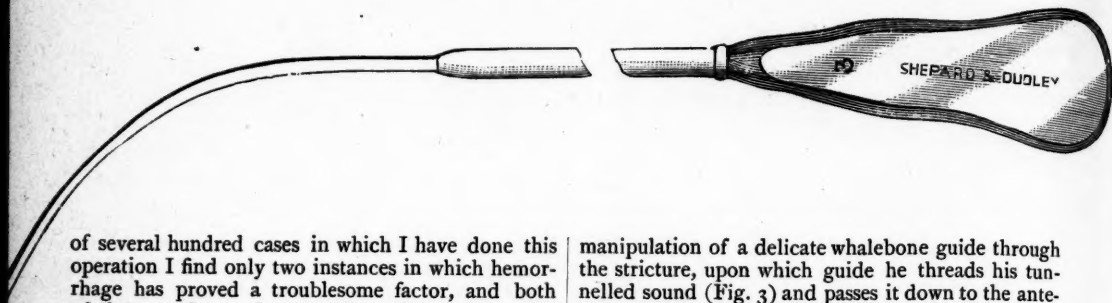
cannot give my unqualified assent, since, in a very large experience, I have found that whenever I have been enabled to pass a guide through the stricture, I have almost always been enabled to perform a successful internal urethrotomy. Mr. Syme has un-

hesitatingly admitted the danger of his operation, and mentions hemorrhage as being often alarming. This trouble I have not encountered in my internal sections, and when I come to examine the records

prefer to select the modification of this operation as proposed and introduced to the profession by my friend Dr. Gouley, of New York.

The main points in his operation consist in the

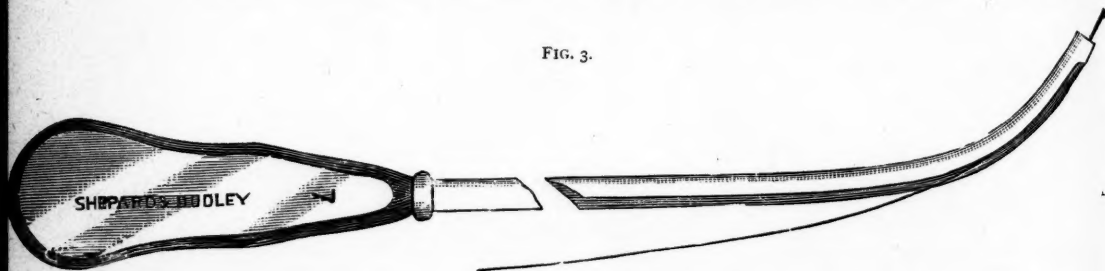
FIG. 2.



of several hundred cases in which I have done this operation I find only two instances in which hemorrhage has proved a troublesome factor, and both of these made good recoveries. In my operation

manipulation of a delicate whalebone guide through the stricture, upon which guide he threads his tunnelled sound (Fig. 3) and passes it down to the anterior face of the coarctation; after which he opens

FIG. 3.



for internal section I always carry my incisions through the upper portion or the roof of the urethra, as by so doing I am convinced the danger of hemorrhage is reduced to the minimum, because there are no arteries to cut, and the small venous bleeding soon ceases. On the other hand, extensive

the urethra from the outside upon the groove of the sound just in front of the stricture. This being accomplished, he searches for the whalebone guide, which then serves to conduct a very delicate, narrow-bladed knife (Fig. 4) into and through the obstruction; then the whalebone guide is removed and its

FIG. 4.

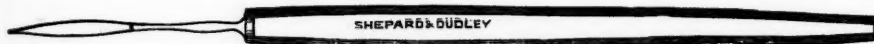
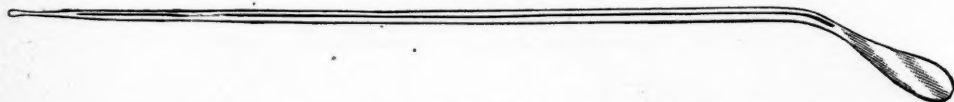


FIG. 5.



incisions made into the floor of the urethra and through the integument are done in the line of important structures, and vessels of considerable size, which, if wounded, give rise to profuse hemorrhage, and not infrequently serious consequences.

Again, in tight strictures it is extremely difficult to carry the small probe-like director (Fig. 2) from the meatus down the urethra and through the stricture; especially is it difficult to do so if there be false passages in the urethra, or within the stricture itself, and even if there be none already formed it is a very easy matter to make them. Hence it is that I should

place supplied by a delicate probe director (Fig. 5), which is pushed on into the bladder, and then the urethra, superficial fascia, and integuments are freely opened. His first incision is made directly in the median line of the perineum from the base of the scrotum to within half an inch of the margin of the anus, and is usually one to one and a half inches in length.

In opening the stricture he directs that the edge of the knife be held downward, and that the coarctation shall be freely divided, taking care to carry the incision into the uncontracted canal about half

an inch posteriorly. The case is then left to nature, and the urethra and the wound to the unobstructed passage of urine. The objections to Dr. Gouley's method are, the large size of the external incision, and the length of time required for the wound to granulate and heal. His incision through the stricture being made in the floor of the urethra endangers bloodvessels of importance, which become difficult of ligation if cut. The wound left to granulate is liable to the formation of numerous fistules, and a long time elapses before the patient is well enough to resume his ordinary vocations.

In this connection, I may refer to the method of Mr. Wheelhouse, which is known as "the Leed's operation." It possesses some advantages over the other forms which have been mentioned, chiefly so, from the ease with which it is performed; but it has still the disadvantage of leaving an open wound in the perineum to heal by granulation, and consequently it is liable to the after-consequences of perineal fistula. Mr. Wheelhouse certainly deserves great credit for the very ingenious and practical manner in which he has planned his operation, and his procedure has the advantage of greatly increased precision over any other form with which I am acquainted. By it an operation which was hitherto one of the most difficult in surgery, has been rendered comparatively easy, and the published reports go to show that the results have been vastly more favorable than from any other method yet described.

This operation is done upon a special staff designed for the purpose, which instrument is fully

the upper angle held up by the button extremity of the staff hooked in it. This opens the urethra and fully exposes the face of the stricture, in which the opening is searched for with a probe-pointed director, which, when it enters the bladder, is turned down so that the groove faces toward the perineum. Then the knife is directed along the groove and the stricture is carefully and deliberately opened on its under surface, and the passage thus cleared. This being accomplished, the probegorget of Mr. Teale (Fig. 7) is passed into the bladder with its concavity looking toward the pubis, so as to receive the point of a catheter, which is now introduced along the urethra until it reaches the gorget, by which it is conducted into the bladder; the gorget is now removed and the catheter tied in to remain for three or four days. After the expiration of that length of time the catheter is removed, only to be reintroduced each day or every second day, so as to keep the urethra in a state of patency until the wound in the perineum has thoroughly healed. The operation is ingenious, and, as a form of "la boutonnière," it deserves to be recommended; still it has, to my mind, the disadvantage which attends all of these operations, viz., leaving an extensive wound in the perineum to heal by granulation, exposing the patient to the dangers of pyæmia, and the liability of urinary fistulæ as a sequence. A very interesting description of this operation is to be found in the *Brit. Med. Journ.*, June 24, 1876, from the pen of Mr. Wheelhouse himself.

The idea has prevailed that, when the external incision is not large and free, urinary infiltration

FIG. 6.



grooved through the greater part, but not through the whole of its extent, the last half inch of the groove being stopped and terminating in a rounded button-like end (Fig. 6). The urethra is opened in

will necessarily take place; but this is an erroneous conception like that which has existed in reference to cutting for stone. The urine, obeying the natural law of gravity, does not infiltrate and burrow under

FIG. 7.



the groove of the staff, not upon the point; in this way, certainly securing at least a quarter of an inch of healthy tube in advance of the stricture; the opening in the urethra being held apart by two pairs of fixation forceps, applied one on either side, and

tissues when it has an open channel through which it can escape. So it is, whenever a stricture has been fully divided, the urine necessarily follows the course of the urethra.

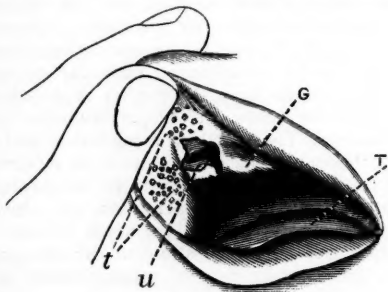
(To be concluded.)



### AN EXAMPLE OF DIRECT INFECTION OF TISSUE BY TUBERCLE.

BY J. SOLIS COHEN, M.D.,  
OF PHILADELPHIA.

A CASE of tuberculosis pulmonum et laryngis now under my care has so well exemplified the direct transport of the infectious principle of tubercle from one surface to another that no excuse is necessary for placing it on record. A man forty-two years of age, who has led an exposed life on the Atlantic Coast of the Eastern States, but who claims that his family history has been good, is suffering with typical chronic tuberculosis of the lungs, larynx, and other organs. The larynx shows great infiltration of



Upper lip of tuberculous subject, showing direct infection. (From a drawing by Dr. Arthur W. Watson.)

T. Tongue.

g. Edentulous gum.

u. Tuberculous ulcer in gum and transition to lower portion of upper lip.

t. Tubercles further out in the lip, where it has lain in contact with the ulcer.

the epiglottis, greater infiltration of the periarthenoid and perisupra-arytenoid structures, with thickening in the anterior and middle portions of the ventricular bands, of the vocal bands, and most likely of subglottic tissues also which cannot be brought under illumination. Aphonia, long present, is due to infiltrating tumefaction preventing approximation of the vocal bands. No ulcerated points can be detected laryngoscopically. On the margin of the edentulous gum of the upper jaw of this patient, and extending across the sulcus between gum and upper lip, is a characteristic tuberculous ulceration, and on those portions of the lip which lie in contact therewith, are numerous points of recent nodular tubercular infiltration, evidently from direct infection. A somewhat similar example, in which the perisupra-arytenoid tissue became infected from a tuberculous ulcer on the epiglottis, is pictured in Fig. 115, p. 503, of the second edition of my treatise on *Diseases of the Throat and Nasal Passages*, New York, 1879.

### ANASTOMOSIS OF RETINAL VEINS UPON THE OPTIC DISK.

BY B. ALEX. RANDALL, A.M., M.D.,  
OPHTHALMIC AND AURAL SURGEON TO THE EPISCOPAL AND THE  
CHILDREN'S HOSPITALS, PHILADELPHIA.

The comparative rarity of this form of anomalous arrangement leads me to place upon record the fol-

lowing case: W. H. S., aged thirty-five, employed in a hosiery mill, visited the eye clinic of the Episcopal Hospital in April because of pain in the eyes and head and dimness of vision, rapidly coming on when using the eyes in near work. The eyes were somewhat watery, the conjunctiva injected, and the anterior perforating veins large and tortuous.

The vision was but  $\frac{20}{XL}$  in each eye, less distinct in the left.

The ophthalmoscopic examination shows in the right eye a disk apparently large, nearly round, with a large shelving excavation extending to the outer margin, and a disturbed crescent of choroid down and out, with a large aberrant artery (lower temporal) emerging from beneath it. The upper veins enter the substance of the disk near the margin and are irregular in their arrangement; the upper artery emerges from the porus. A prominent tongue of tissue, arising from the centre of the disk and extending downward to the margin, almost hiding the ending of the lower vein to its temporal, and the origin of the lower artery to its nasal side, constitutes the most marked anomaly. It seems to blend with the thickened sheath of the vein at the lower disk margin. The eye shows low hypermetropic astigmatism, with considerable disturbance of the choroid and some tendency to accommodative spasm.

In the left eye the disk is of similar size and form, with a small and deep central excavation, into the outer portion of which most of the veins enter.



There is considerable choroidal disturbance at the outer margin, with pigment-heaping and absorption, the lower portion of the crescent seeming to be in a plane deeper-lying than the general choroidal level.<sup>1</sup> The lower artery arises near the lower nasal margin of the disk, the upper from the upper part of the porus. A large vein (upper nasal) enters the

<sup>1</sup> The cut is not strictly accurate as a portrait, but depicts faithfully the relations of the veins constituting the anomaly.

substance of the disk in the middle of the upper nasal quadrant. Connecting this with the adjacent vein which passes into the porus is a straight communicating vein about one-half as large as either of the vessels which it unites, and nearly at right angles to the course of each. Its relation to each vessel is unmistakable, and there is no neighboring vessel with which it might be confused. The general condition of the choroid is almost as bad as in the periphery of the other eye. The refraction is as in the other, less masked by spasm of the accommodation.

It may be noted that there is marked distortion of the nose to the left, but no other notable asymmetry or anomaly of the head.

1806 CHESTNUT STREET.

## MEDICAL PROGRESS.

**THE ABSORPTION OF DRUGS FROM LANOLIN OINTMENTS.**—In the *Vratch*, No 23, 1886, p. 421, DR. P. V. BURJINSKY describes the results of his experiments, carried out in Professor V. A. Manassein's clinic. The preparations of lanolin, used by the author, were quite pure (obtained either directly from Jaffé and Darmstätter, or from Professor A. W. Poehl's laboratory in St. Petersburg). The ointments were rubbed with the palm of the hand, under strong pressure, into the internal surface of the arm and forearm, the procedure lasting from fifteen to twenty minutes. Only fixed (non-volatile) and indifferent (non-caustic) substances of known chemical composition (such as ferrocyanide of potassium, hydrochlorate of quinine, sodium salicylate, and salicylic acid) were used. The question of cutaneous absorption was decided exclusively on the ground of the drugs passing in the urine. In seven of twelve experiments (in four with ferrocyanide of potassium, two with quinine, and one with sodium salicylate) the results were entirely negative; that is, not a trace of the drugs employed was discovered in the urine, the analysis being repeated hourly from six to eighteen times. In the remaining five (one with sodium salicylate and four with salicylic acid), there was obtained the well-known violet reaction with perchloride of iron; it appeared from one to four hours after the inunction. But the same reaction was obtained, also, two hours after the inunction of the same amount of an ointment made of salicylic acid and hog's lard. Having considered the results above given, Dr. Burjinsky lays down the following propositions: 1. So far as penetration of drugs through the skin is concerned, lanolin seems to have no advantage whatever, comparatively, with other fats used as a basis for ointments. 2. Lanolin is a good constituent for ointments, since (a) it is a neutral fat not liable to become rancid; (b) it is easily miscible with glycerine fats and water; and (c) it gives delicate, fine ointments. In conclusion, the author draws attention that it is necessary to ascertain whether the process of preparation of cholesterolin-fat gives security against any possibility of infection with anthrax.—*London Medical Record*, July 15, 1886.

**REPLANTATIO DENTIS.**—GREVERS records the case of a fourteen-year old boy who fell from a height upon his face, whereby a first upper incisor tooth was com-

pletely removed from its alveolus. Then the alveolus was cleaned, the tooth disinfected, replaced with considerable pressure and resultant pain, and maintained in position by elastic slings attached to the neighboring teeth. In six weeks the tooth had regained its firm attachment and it was in no wise distinguishable from its fellows.—*Centralbl. f. d. med. Wiss.*, July 24, 1886.

**BICHLORIDE OF MERCURY AND TINCTURE OF BELLADONNA IN MEMBRANOUS CROUP.**—DR. J. H. JONES writes as follows to the *New York Medical Journal* of August 21, 1886:

I have for some years been in the habit of treating this disease with a combination of corrosive sublimate and belladonna. These drugs are recommended for this complaint in almost every work on therapeutics, but I am not aware that they have ever been given conjointly. I have found that small doses of the bichloride (one-fiftieth of a grain), administered in conjunction with tincture of belladonna (two to five minims), every half hour for a child two years old, is a very successful method of dealing with this dangerous disease of childhood. The secret of its success is in its persistent administration, even when the symptoms are apparently most unfavorable. I have several times witnessed a happy termination to the disease when other practitioners with whom I was associated entertained scarcely a hope of recovery. It is advisable to commence the treatment by administering an emetic, so as to dislodge the already formed membrane. Probably much of the benefit derived from this mixed treatment is due to belladonna, and it is astonishing what large doses of this drug children can tolerate. During the progress of the disease the strength must be maintained by a liberally nutritious diet and stimulants, for I must say that when recovery takes place the patient is left very anæmic and weak. This is not very apparent while the medicine is being given, as every evidence of it is partially masked by the physiological effects of the belladonna.

**THE DIURETIC ACTION OF WATERMELON.**—In the course of a prolonged study of remedies used in Russia as diuretics, POPOFF (*Vratch*, No. 4, 1886) finds that watermelon has been commended as an extremely cheap but effective substitute for grapes in the treatment of chronic congestion of the liver, chronic intestinal catarrh, etc. It is extensively used by the peasantry in Southern Russia (especially near the river Don, and in the Caucasian districts) in the form of the freshly expressed juice, as a diuretic draught in cases of dropsy, urogenital affections (especially gonorrhœa), etc. The author experimented with the inspissated fresh juice or syrup of the fruit, and with commercial melon-honey (*arboosnyi miod*). The diuretic action proved most striking; when animals received from 50 to 100 grammes of the syrup (with food) in twenty-four hours, the daily quantity of urine was three or four times greater than under ordinary conditions; again, on intravenous injection of the syrup "the urine for several minutes flowed in a stream from a canula tied into the ureter." On the subcutaneous injection of 0.4 to 0.7 gramme into frogs the syrup rapidly slows the cardiac action up to complete arrest in diastole, and produces prostration with loss of voluntary movements, while reflex action

and the excitability of the motor nerves and muscles remain intact. When very large doses are used, in the latest stages there is observed, also, a failure of reflexes and of nervo-muscular excitability, but the phenomenon is then undoubtedly nothing but an ordinary symptom of præmortal agony. In dogs the internal administration of 500 grammes at a time produces no effect except powerful diuresis. Intravenous injection of one to two grammes of the syrup causes an immediate increase in the secretion of the urine, the latter assuming a dark color and containing sugar. This increase lasts for ten to sixty minutes, and is accompanied only by a slight fleeting decrease in the blood-pressure. On the injection of 0.25 to 0.5 gramme for each kilogramme, a considerable fall of the pressure and a great acceleration of the pulse rapidly follow. An intravenous injection of 3 grammes per kilogramme produces a further fall of pressure and a fleeting increase, with a subsequent sudden enormous decrease in the frequency of the pulse, the animal dying from cardiac paralysis. Experiments show that the quickening of the cardiac action is dependent upon the syrup acting on the peripheral ends of the vagi. In all cases intravenous introduction of the syrup rapidly produced a strong sedative effect, "the animal remaining strikingly quiet, and giving no response to tactile or even pathic irritation." Another group of experiments showed that the diuretic action of melon-syrup was dependent mainly upon its direct influence on the renal tissue.—*London Medical Record*, June 15, 1886.

**THE PREVENTION OF INSANITY.**—In a paper recently read before the Connecticut Medical Society, DR. GUSTAVUS ELIOT presents the following conclusions, which, although they have no claim to the merit of novelty, are none the less important:

In order to prevent the occurrence of insanity it is necessary

I. To avoid the transmission of a hereditary tendency thereto, by discouraging marriage between persons of like tendencies in this direction.

II. In persons with a hereditary or acquired tendency in this direction, to counteract the tendency as far as possible.

1. By insuring regularly an adequate amount of sleep, and a sufficient quantity and variety of nutritious food.

2. By securing recreation and relaxation.

3. By maintaining the action of the secretory and excretory organs.

4. By avoiding entirely the use of alcohol and other cerebral stimulants.

5. By cultivating habits of self-control.

6. By encouraging objectivity rather than subjectivity of thought, breadth, and not narrowness of mental activity.

7. By avoiding anxiety and excessive mental exertion.

8. By taking disappointments philosophically, forgetting them quickly, and not brooding over the unpleasant occurrences of the past, but anticipating with cheerfulness the events of the future.

**FURTHER INVESTIGATIONS ON THE BACILLUS OF TYPHOID FEVER.**—NEUHAUSS has continued his study of

the contents of the roseola spots of typhoid and, as before, finds in the blood therefrom obtained a characteristic bacillus. Only the blood from these spots contains the bacilli, a fact which inclines him to the opinion that the cutaneous lesions are due to "bacterial emboli." In nine out of fifteen cases he has succeeded in making cultures of the typhus bacillus from blood thus obtained.

Neuhauss claims also to have found the bacilli in the four months' fœtus of a woman who aborted soon after a relapse of typhoid fever. Inasmuch, however, as a conclusive proof of the passage of microorganisms from the maternal to the foetal circulation is not yet at hand, the statement demands further investigation.—*Centralbl. f. klin. Med.*, July 31, 1886.

**EXTIRPATION OF THE SPLEEN.**—PROF. CECI, of Genoa, successfully removed the spleen in a girl, aged seventeen (*Gazz. degli Ospitali*, May 23). The patient, who was imperfectly developed and ill-nourished, had had an abdominal tumor from birth. A large floating spleen was diagnosed. It interfered with the patient's walking, and at times gave rise to severe attacks of pain extending from the left hypochondrium to the præcordial region, radiating into the left arm, and followed by dyspnoea and unconsciousness. The removal of the organ was therefore decided upon. The operation was performed on March 20. The strictest antiseptic precautions were used, and the surrounding atmosphere was at a temperature of 30° C. (86° F.). Anæsthesia was commenced with bichloride of methylene; but upon opening the abdomen grave symptoms of suffocation appeared, which necessitated the suspension of the operation for nearly thirty minutes. Chloroform was then employed. The incision was twenty-three centimetres (nine inches) long; and extended through the linea alba, an equal distance above and below the umbilicus. The pedicle was secured with a triple ligature of catgut and carbolized silk, and was left at the bottom of the wound. The peritoneum was sutured separately. The abdominal walls were fastened by three metallic points, after Billroth's method. The extirpated organ with its contained blood weighed about 2400 grammes (a little short of five pounds). The whole operation, including the above-mentioned interruption, occupied an hour and a quarter. Furious delirium came on the following morning with the nervous symptoms, resembling *angina pectoris*, from which the patient had been in the habit of suffering. For two days, the respirations were from 70 to 80 a minute, and the pulse could not be counted. Under treatment by oxygen and nutrient clysters this alarming state passed off. On the fourth day, fever arose. On the eighth day, the first dressing was removed and the wound was found actively suppurating. The suppuration, according to the report, yielded to vigorous antiseptic treatment. In the following days, however, occurred two erysipelatous infections, coincidently with the reception of two erysipelatous patients in neighboring surgical wards. At the time of the report (April 22, 1886) the patient was in excellent condition. The abdominal incision had nearly healed, showing only a superficial wound remaining. This is stated to be the thirty-ninth time the operation has been performed. The mortality has been 78 per cent.—*London Medical Record*, July 15, 1886.



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## EXCISION OF VARICOSE VEINS.

In speaking of the method of Antyllus for the treatment of aneurism (THE MEDICAL NEWS for May 1 and May 29, 1886), we have already expressed the opinion that modern improvements in the mode of performing surgical operations and in their after-treatment make it possible to form more favorable opinions of certain operations than were once justifiable. This is the case with the method of excision of varicose veins. There was a time when it could not be questioned that any method which attacked them through an open wound made the patient liable to serious accidents, and even to death. This fact accounts for the preference evinced by some of the most experienced and skilful surgeons for the employment of caustics, and the efforts made to devise a satisfactory method of subcutaneous ligature. But, at the present time, when the most intolerant parts are attacked with impunity every day, it is not an act of temerity to cut down upon, and remove portions of, veins which are enlarged and tortuous, so as to relieve the often distressing symptoms to which they give rise. Indeed, something more than has been effected in this direction might have been hoped for from the elaborate papers of DR. SAMUEL W. GROSS on wounds of the veins, published in the *American Journal of the Medical Sciences* in 1867, in which he made it clear that the veins are not so intolerant of operative interference as has been supposed.

This fact is better understood now than it was then, and so it is not surprising to find a revival of

interest in the method of treating varicose veins by excision, which is as old as the time of Celsus. Its latest advocate is DR. KENDAL FRANKS, who publishes an interesting paper on this subject in the *Dublin Journal of Medical Science* for May, 1886. In this paper Dr. Franks, after discussing the pathogenesis of varicose veins—speaking of those of the legs alone—describes his method of excision, and the cases to which he believes it to be suited. In slight cases, in old and debilitated subjects, and in cases in which the condition is due to irremediable extrinsic causes, he thinks palliative measures are to be preferred. But where the cause is intrinsic, or is extrinsic and remediable, and where the patient is a young, or healthy adult, he would operate. In fact, he has operated in more than twenty cases, and in none has he seen phlebitis, erysipelas, or pyæmia, formerly the great terrors of the operation. Of course, he uses aseptic precautions. He washes the leg with corrosive sublimate solution, or oil of eucalyptus; places a ligature around the limb above the site of the proposed incisions, so as to distend the veins; makes a clean cut over the vein; divides the subcutaneous tissue on a director; passes a strong catgut ligature around the vein at its lower part; seizes it immediately above the ligature in a pair of forceps, cuts through it below them, and draws it out, ligating and dividing any radicles met with. Finally, he places a ligature around the highest point of the strip which has been dissected out, and cuts it off just below this ligature. He then irrigates the wound with corrosive sublimate solution, dusts it with powdered iodoform, and closes it up. Formerly he used to insert a drainage tube; but he no longer does so. If necessary, he removes several sections of the vein or veins in this way, and he also operates at once on both legs, if they both need it. After the operation he bandages the leg, or legs, from the toes to above the knees. As a rule, he leaves the dressings undisturbed for eight or ten days, and generally finds the wounds healed by first intention when he examines them. In a few cases he has had some suppuration, but it did no more harm than to delay the healing for a little while. He does not state that he puts his patients to bed after the operation, but it is to be assumed that this is done.

The confidence of Dr. Franks in this method is not surprising, in view of the good results he has obtained by it, and especially in view of the fact that he believes he secures a radical and permanent cure. His own conclusion is that antiseptic excision, in suitable cases, is a means of treating varicose veins which offers the hope of far better and more permanent results than any other method hitherto devised, and that with ordinary care it is far safer. This conclusion certainly seems warranted by the argument of Franks, and would justify imitation of his example.

It is interesting to note that this experience furnishes another illustration of the fact that the practice of modern surgery returns, from time to time, to the simple and direct methods of the ancients; and with its gains in the direction of more accurate *technique* and more perfect conditions of asepsis, secures better results by once abandoned methods than have been obtained by the methods to which men were driven by the dangers of the pre-antiseptic period. In operations upon the skull, in operations on the abdomen, in operations upon the bladder, the same thing is being seen; and surgeons are continually reverting to the plainer and more direct methods of the earliest surgeons. Simplicity and directness seem to be coming into fashion. Even the very features of the antiseptic method of wound treatment, which is not yet old, are becoming simplified; so that it may be hoped that before long the principles of surgery will have attained a degree of perfection which was not possible in the earlier, ruder days, nor yet in the days of extreme reaction, in which too much stress was laid upon unimportant details.

#### THOMSEN'S DISEASE.

IN 1876, THOMSEN, a Schleswig physician, described a remarkable affection of the muscles to which he was himself subject, and which had existed in many members of his family through, at least, four generations. The disease has, since then, become well recognized, and is usually known by the name of the original describer, or by the term *myotonia congenita*, suggested by Strümpell. In a recently issued monograph, *Die Thomsen'sche Krankheit*, Leipzig, 1886, ERB has analyzed all the recorded cases, and presented an elaborate study of the affection, based upon three original observations.

The disease involves the voluntary muscles, and, as a rule, appears very early in life; indeed, in a majority of cases, it is probably congenital, and often affects several members of the same family. It is characterized by a remarkable stiffness and tension of the muscles on attempting to perform any voluntary movement. This is particularly noticeable after the subject has been at rest for some time. Occasionally the entire body becomes stiff, and the patient may be unable, for a few moments, to move a limb. Usually the tension and stiffness pass off with continued motion, and the action of the muscles becomes as free as in a normal individual. Rapidity of muscular action is impossible, as with each energetic willed movement the muscles involved pass into a tonic, long-continued, painless contraction which is only gradually relieved. In all other respects the subject of this disease is healthy, and presents neither psychical nor somatic anomalies. The muscular system is unusually well developed,

but the strength is scarcely proportionate to the size and appearance of the muscles.

Hereditary influences play an important part in the etiology, and the disease resembles several other myopathic affections in appearing early in life and attacking several members of the same family. It is essentially a chronic malady, and may persist, with variations in intensity, during the entire life.

Of the recorded cases Erb has selected twenty as typical instances, and has excluded twelve or fifteen as doubtful. A careful study of his three cases led to the discovery of certain symptoms of diagnostic importance, hitherto overlooked, and also to certain facts which throw light on the pathology of the disease. The mechanical excitability of the motor nerves is not heightened, and the faradic and galvanic reactions are essentially normal; but the muscles, on the other hand, show a greatly increased excitability and qualitative changes with galvanism. AnS acts as strongly as KaS, often, indeed, more strongly, and the contractions are slow, tonic, and long continued. The strong faradic current induces in many muscles undulatory contractions. Great stress is laid upon this marked difference in the nerve and muscle reactions as the important diagnostic sign of the disease.

In the portions of the muscle excised during life remarkable changes were found, consisting in enormous hypertrophy of all the fibres, increase in the nuclei, indistinctness and vacuolation of the substance, with thickening of the interstitial connective tissue. An opportunity of examining the nervous system has not yet arisen, but Erb holds that the evidence points strongly to a pure myopathic affection, and he would directly connect the disturbance in function with the histological changes discovered in the muscles, the precise nature and mode of origin of which still remain in doubt.

The affections with which Thomsen's disease is most likely to be confounded, are tetany and pseudo-hypertrophic muscular paralysis. The tonic spasm in the muscles occurring at intervals resembles tetany, but the contractions are never so strong, are not painful, and do not occur spontaneously, but always on attempting a voluntary act. The hereditary and chronic character of Thomsen's disease also afford valuable diagnostic features. The nerve and muscle reactions are entirely different, as the excitability of the nerves in tetany is heightened, while that of the muscles is normal—the reverse of what occurs in Thomsen's disease. In several instances the affection has been confused with pseudo-hypertrophic paralysis, with which, however, it has only a superficial resemblance in the hereditary origin, the early onset, and the increase in volume of the muscles.

The disease is probably incurable and does not appear to lessen the duration of life. Erb recommends massage and general faradization as suitable agents, the former for direct action on the muscles, and the latter as a tonic to the trophic centres.

#### A PROPOSED MODIFICATION OF PORRO'S OPERATION.

DR. JOHN BARTLETT, of Chicago, proposes to modify the operation of Porro by first opening the uterus with a thermo-cautery instead of the knife, and, after the removal of the fœtus and secundines, to invert the organ, clamp the cervix in the vagina, and then amputate as in the Porro method, leaving the stump in the vagina. The proposition is ably presented in a paper which was read before the Chicago Gynecological Society on June 26th. This plan was proposed in Europe in the early days of the Porro method, to avoid the dragging of the pedicle upon the abdomen, and the risk of dropping in the stump for the same purpose, as devised by Gustav Veit, of Bonn; but no one in the six years that have passed has thought sufficiently well of it to give it a trial. It is, therefore, not new, and at the present time the Porro method is being in a measure superseded by a less dangerous one in an improvement of the old Cæsarean operation devised by Dr. Sänger, of Leipzig. There is no hope from theoretical reasoning, that the Bartlett plan would ever be able to save 80 per cent. of the women, and nearly 100 per cent. of the children, as has been done in Continental Europe, under the Sänger method, and it is, therefore, only to be regarded for its ingenuity.

The Porro operation of to-day has not the status that it had three years ago, or even one year ago, for the wonderful results under the old Cæsarean section with the Sänger improvement have excited the attention of some of the most famous of the followers of Porro, who are now making trial of it because of its lesser fatality. When the operators in two maternity hospitals have saved 16 out of 17 women, and all of the children, by it, there must be more in it than an accidental train of good fortune. The Porro method, even under Chiara, of Milan, was made to appear more dangerous by comparison, and Chiara himself reports as an entire success a trial of the new plan made just three days after Dr. Bartlett read his paper.

When we consider that in the year from July, 1885, to July, 1886, there were 20 Sänger operations in Europe, with a loss of only 2 women and possibly child, we can comprehend the futility just now of recommending any other scheme of delivery in cases of pelvic obstruction. Mr. Lawson Tait, having lost three women by the Cæsarean section,

and saved one by the Porro method, may prefer the latter, and rate the mortality of the former at over 99 per cent., but he cannot establish his estimate in view of these incontrovertible facts. Until a wiser man devises a safer method, we shall recommend that of Sänger as simplified by Leopold, for it has saved 90 per cent. of the European cases in the past year. In 1880, there were 27 Porro operations (true) in Europe, resulting in the saving of 10 women and 21 children. In 1883, there were 12 recoveries and 10 deaths, which is the best year in Dr. Godson's table. In no year were 18 women saved from any number of operations. The 31 Sänger Cæsarean operations of Europe have been the work of 13 operators in Germany, Austria, France, and Italy.

#### REVIEWS.

MONTHLY NURSING. By A. WORCESTER, A.M., M.D., Fellow of the Massachusetts Medical Society. 8vo. pp. 250. Boston: D. W. Mason, 1886.

THE author of this little volume has been in the habit of lecturing to nurses in the Boston Lying-in Hospital, and more recently in the Waltham Training School, and this may be said to be his text-book designed especially for their instruction. It aims rather high for the class of women who usually offer themselves to nurse parturient cases, but not too much so for those who ought to be trained for this important branch of nursing. The better educated and more refined women who enter training schools generally prefer to nurse ovariotomies and other surgical cases, neurasthenias and other nerve maladies, etc. Dr. Worcester designs by his book to teach what is to be done in cases of emergency, and to give an obstetrical training, so that the nurse may be prepared to act in cases where the physician is not on hand at the delivery. Although he adds a glossary to the end of the book, we believe it would have been better either to have avoided technical terms, or to have explained them as in *Blundell's Midwifery*, at the bottom of each page where they occur. The general aim of the book is to teach nursing only, and to make the nurse observant, careful, and competent in her position. There is no reason why women with a fair degree of education should not be trained to nurse in cases of labor, and be well compensated because of their superior knowledge. There are many female medical students and graduates who might do better in this capacity than in an overcrowded profession, but for the fact that so few of them have the requisite physical health and strength, but there are others in various trades and occupations in which they make a bare living, who have these requisites and might better their resources in nursing. The volume closes with a section upon diet. We cordially recommend the work, and believe that it will be useful not only in the hands of nurses, but in those of many physicians who need to know how to direct them.



## SOCIETY PROCEEDINGS.

### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

*Tenth Annual Session, held at Greenwich, Conn.,  
August 25, 26, and 27, 1886.*

THURSDAY, AUGUST 26.—SECOND DAY.

#### MORNING SESSION.

DR. G. H. TILDEN, of Boston, read a paper on  
TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY TO  
THE MEDIAN NERVE.

E. F., fifty-five years of age, was wounded in the wrist by a circular saw, in November, four months before coming under observation. The wound was parallel with the long axis of the limb. It was sewed up and healed in about ten days. Three or four days after the infliction of the injury, there were loss of the tactile sense and a feeling of numbness in the last two phalanges of the fore- and middle-fingers. This has continued and steadily increased. There was at first a slight feeling of numbness in the thumb, but this gradually diminished until it disappeared. Three weeks after the accident bullæ appeared upon the terminal phalanx of the middle finger. Similar lesions have developed from time to time upon the last two phalanges of the fore- and middle-fingers. The bullæ appear every two or three weeks and are unaccompanied by any subjective sensation. These leave superficial excoriations which heal in the course of ten days. The skin over the affected phalanges is of a white color and of a glossy texture. The growth of the nails is unaffected. There was entire loss of sensation in the skin covering the affected phalanges. The right hand is capable of exerting only one-half the power of the left. The first and second interossei muscles exhibited the reactions of degeneration. Six weeks' treatment with the faradic current caused decided improvement in all the symptoms. During this period only one bulla formed. He then stopped treatment and returned to work. Three weeks later all the former symptoms suddenly returned. It was proposed to the patient that an incision be made over the seat of injury with the view of determining the exact condition and if possible remedying it. The patient has not since been seen.

Whether the trophic nerves exist as individual and special nerve fibres or whether the motor and sensory nerve fibres are the ones by which the nutrition of the tissues is governed, is unknown. The latter view was considered by the author as the most rational. Injury or disease of the motor or sensory nerves as well as disease of the ganglia and central nervous system, may disturb not only motor power and sensation, but also the nutrition of the tissues. That it does so is by no means the case, but why trophic changes should take place in one instance and not in another is not clear. A number of cases have been reported showing that such changes are more apt to follow partial injury of a nerve than complete section. The changes commonly seen in these cases are the so-called glossy skin and vesicular and bullous eruptions followed by superficial excoriations. The treatment of these cases consists in the use of electricity and the application of blisters over the seat of injury. A last resource is to cut down upon

the affected nerve and endeavor to relieve any constriction or pressure which may be found. If no such condition is detected, resection of a portion of the nerve might be advisable, since complete section is not apt to be followed by spontaneous trophic changes, and since it has been found by some observers that resection of a portion of the affected nerve is sometimes followed by arrest of the trophic changes.

DR. JAMES C. WHITE, of Boston, then presented a paper on

#### NATIVE PLANTS INJURIOUS TO THE SKIN.

He pointed out that the number of plants growing native and cultivated in the United States, which are capable of exciting some degree of dermatitis by contact, is much larger than is generally supposed; and that cases of such inflammation of the skin not infrequently occur without being understood, because the patient has not been exposed to the two or three plants which alone are considered to be poisonous. He enumerated over fifty species which have irritating properties when brought in contact with the skin. With reference to rhus poisoning he said that the rhus toxicodendron is comparatively innocuous, while the rhus venenata is the most poisonous species of this plant. The treatment is the ordinary treatment of dermatitis. There is no specific for this form of dermatitis.

DR. H. G. PIFFARD, of New York, read

#### SOME NOTES ON DRUGS,

in which he referred briefly to several recently introduced preparations.

DR. F. B. GREENOUGH, of Boston, presented

#### A FEW ADDITIONAL NOTES ON PSORIASIS.

The paper was a continuation of the tabulation of cases of psoriasis seen during the past year. The facts previously noted with reference to age, sex, the time of the first appearance of the disease, and the number of cases, had been confirmed. In addition to these statistics, the author, owing to the fact that a statement he had made at the last meeting in reference to the general health of the patients, had been doubted, had attempted to obtain further testimony upon this point. He found that, as a rule, patients with psoriasis were above par in general health and strength. He had records of twenty-nine cases of psoriasis out of 1220 cases of skin diseases, giving a ratio of cases of psoriasis of two and one-third per cent. The youngest case was nine years of age, while the eldest was fifty-seven years. The reader thought that the interesting deductions to be drawn from his cases were the facts, that while nine cases showed symptoms of psoriasis under ten years of age, one was first attacked at the age of fifty-seven years; that out of twelve cases in which evidence could be obtained, four gave a decided history of the existence of disease in some member of the family, and that these cases showed such a high standard of general health. He considered this latter fact as a strong argument against the possible connection between psoriasis and syphilis. He had never seen psoriasis of the hands unassociated with evidences of the disease in other parts of the body.

DR. A. R. ROBINSON, of New York, described a case of

#### CHONDROMA OF THE UPPER LIP.

The tumor occupied the right side of the upper lip of

a man thirty-six years of age. It had been growing for two years and was one inch in length by three-fourths of an inch in diameter. The mucous and cutaneous structures were freely movable over the tumor, which was sharply limited, somewhat encapsuled, and nourished by a small artery entering at the base. Microscopical examination showed the tumor to consist of embryonic, gland and connective tissue. The gland tissue was formed of hypertrophied mucous glands and new gland tissue. The amount of new gland tissue could not be correctly estimated, because much that resembled gland tissue, represented an early stage in the process of cartilage tissue formation. The connective tissue was myxomatous, fibrous, and cartilaginous. The myxomatous was present principally at the periphery and did not represent oedematous fibrous tissue. Fibrous connective tissue was present chiefly between the islands of cartilages, the bundles were small and the fibrils very fine and often rather indistinct in outline. There were several islands of cartilage the largest being in the central part of the tumor. All varieties of normal cartilage were present, viz., hyaline, fibrous, and reticular, and also the variety met with in the heads of cephalopods, namely cartilage with ramifying or branched cells, *chondromes à cellules ramifiées*. The cells showed great diversity of form and size. The body of the branched cells presented a great variety of form. Some were surrounded with a capsule, but in the majority of cases this was absent, or only faintly indicated. In some places the islands of cartilage had joined each other, but usually they were separated by the other constituent tissues. The affection is considered to be very rare. It has been described by Paget under the name of labial glandular tumors.

DR. P. A. MORROW, of New York, reported a case of KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE TONGUE AND LEUKOPLAKIA BUCCALIS.

The patient, C. O., a sailor, aged twenty-one years, came under observation in December, 1885. Five years previously, soon after beginning his seafaring life, he noticed a number of blackish points upon the back of the hands, some of which he squeezed out. Soon afterward these appeared upon other parts of the body. They improved when he was on land, but were aggravated when he was at sea. The entire surface of the body, with the exception of the face, palms, and soles, was found to be the seat of the follicular disorder. The ducts of the sebaceous glands were occupied by comedo-like bodies, projecting sometimes one-fourth to one-half an inch above the surface. From many of the follicles small white hairs protruded. The comedos, when pressed out, were hard and dry. The hard portion of the comedo was continuous with an adhesive substance dipping deeply into the follicle. There was no evidence of irritative or suppurative action. They were not accompanied with itching.

The tongue was large and rough to the touch; the surface was deeply fissured, the fissures extending to the submucous tissue. The buccal mucous membrane presented a bluish-white appearance, thickened and raised in places, forming distinct plaques, which were superficially fissured. The patient stated that the tongue had been white and a little sore ever since he could remember. The absence of irritation, or marked

sensitiveness of the fissured organ was quite noticeable. Examination seemed to exclude the possibility of a syphilitic origin. The speaker referred to other cases which had been reported. He objected to the term ichthyosis, since that suggests a disease of a different nature. He selected the term *keratosis follicularis* as more correctly expressing the pathological condition present, as well as indicating the anatomical seat of the disorder. Drawings representing the microscopical appearances of the lesions were presented.

While in the hospital the patient improved decidedly under the use of local applications of linseed oil. But within a short time of the discontinuance of the treatment, the condition became as marked as before treatment was employed.

#### EVENING SESSION.

DR. J. E. GRAHAM, of Toronto, presented

#### A CLINICAL STUDY OF SCLERODERMA.

He first related the histories of two cases of this rare disease, one of which occurred in the practice of Dr. Smith, of Seaport, Ont., and the other was referred to him by Dr. Jenner, of Pictou. The first patient, Mrs. R., forty-seven years of age, had previously suffered from rheumatism. The hardening of the skin began in March, 1882, and was first noticed over the back of the neck. It gradually spread, so that in about ten weeks the integument over the greater part of the body was affected. The movements of the limbs, as well as those of respiration, were impeded. The internal treatment adopted was liquor ferri iodidi and liquor arsenitis. A faradic bath over the surface of the skin was used. In six weeks the skin began to grow softer, and in ten months the patient was quite well. There has been no return of the difficulty.

The second patient, Mr. H., aged thirty-seven, came under observation in May, 1886. There was a history of hereditary rheumatism. The disease had commenced some months previously. The first symptoms were stiffness of the limbs, with oedema of the lower extremities; then hardening of the skin over the hips was noticed. This gradually spread, and was accompanied with pigmentation. The treatment consisted in the administration of potassium iodide at first, and latterly of salicylate of sodium. There has been some improvement under this treatment.

In his remarks in connection with the disease, the speaker referred to the following points: 1. That the disease is found principally in temperate climates, and occurs in seasons when there are sudden changes in the weather; 2. That it is more closely related to rheumatism than has been supposed; 3. That, although morphea has in all probability a similar pathological origin to scleroderma, yet the clinical distinctions are so marked that at present it is expedient to treat it under a different name.

DR. L. N. DENSLOW, of St. Paul, in one case of scleroderma in which were two large plaques on each pectoral region, had seen benefit follow the daily use of the constant current, continued for six months.

DR. DENSLOW then reported a case of

#### CARCINOMA CUTIS.

The patient, aged forty-nine, had had a severe right-sided pleurisy, and presented the physical signs of ab-

sence of the right lung. The skin of the right chest from the second to the seventh rib, and from the posterior border of the axilla to the median line, was covered with a nodular new growth, which presented no ulceration. Around the nipple the nodular mass for an area of six square inches reached a thickness of an inch. The older portions of the growth were covered with thickened epidermis with thick brown scales. There was slight enlargement of the axillary glands. The whole mass was free from the fascia. It was not painful on pressure, but was the seat of occasional neuralgic pains. The duration of the growth was seven months. The patient died four months after coming under observation. The autopsy showed obliteration of the right lung. The left lung presented many small, solid nodules. In the mesentery there was a nodule an inch and a half long by one-half inch in diameter. The microscopic examination of these masses showed that in them all connective tissue preponderated. The growth on the skin occupied the papillae and the deeper portion of the corium, and here, too, connective tissue greatly preponderated.

DR. I. E. ATKINSON, of Baltimore, referred to the extremely malignant nature of these growths. In a case of his own which presented appearances similar to that of Dr. Denslow's case, the disease ran its course in two or three months. These cases are so malignant that it would seem that no operative procedure is justifiable.

DR. R. W. TAYLOR, of New York, referred to two cases, both in men, which were, for a time, looked upon as cases of cancer of the nipple. They eventually turned out to be cases of hard chancre; in one the induration was so great that carcinoma was strongly suspected.

DR. I. E. ATKINSON, of Baltimore, read a paper on

#### SCARLET FEVER AND SCARLATINIFORM ERUPTIONS FOLLOWING INJURIES AND OPERATIONS.

He first referred to the cases on record. In many of these it was held that the affection had been a true scarlatina. In others the scarlatiniform rash was of a septic origin. Various drugs which are frequently prescribed in traumatic cases will produce such eruptions, special reference being made to the cinchona alkaloids. The following conclusions were presented:

1. Unprotected persons who have suffered injury or undergone operation are much more liable to scarlet fever than are healthy individuals. This probably holds good with reference to other infectious diseases.

2. When an epidemic tendency to these symptoms prevails after injuries and operations, it may be concluded that true scarlet fever is present.

3. Septicæmia is occasionally accompanied with a scarlatiniform eruption.

4. Medicinal eruptions, especially from cinchona alkaloids, may follow accidents and injuries.

DR. P. A. MORROW, of New York, said that a rash often follows the use of antipyrine, which frequently simulates scarlatina, although it is usually of a more measles character. Again, carbolic acid and iodoform dressings will often produce eruptions presenting the objective appearances of scarlet fever. There is another eruption known as the "doctor's rash," which appears upon the persons of sensitive individuals stripped for examination.

DR. L. N. DENSLOW related the case of a young woman who stated that a scarlatiniform eruption always appeared upon her body on exposure to sunlight. In order to test the matter, she was directed to come to the hospital closely veiled and gloved. She was then placed in a dark room and one glove removed. A ray of sunlight was then allowed to fall upon the hand and at once a strip of erythema appeared. The same occurred on the face when it was exposed.

DR. I. E. ATKINSON, in closing the discussion, said that while he had seen the rashes mentioned by Dr. Morrow, he did not consider them in his paper, because he was specially interested in those scarlatiniform eruptions following traumatism, and he referred to medicinal eruptions only incidentally.

FRIDAY, AUGUST 27—THIRD DAY.

#### MORNING SESSION.

DR. S. SHERWELL, of Brooklyn, made some

#### REMARKS ON AND QUERIES AS TO THE RELATIVE FREQUENCY OF MOLES AND THEIR PATHOLOGICAL CHANGES ON THE HEAD AND FACE.

This class of affections receives very little consideration in works on dermatology, but the author's experience had led him to pay increased attention to these formations. In looking up the statistics of one of the institutions with which he is connected, he found that in a period of eighteen months, he had seen forty-seven cases suffering with neoplastic and hypertrophic growths. In thirty-six of the cases, the growths occupied the face and head. In only eleven cases were the growths found on the body and limbs. Seventeen of the cases, in which the growths were on the face, were classed as epithelioma. It might be urged that the exposure of the unclothed portions of the body would lead to the formation of neoplasms and the occurrence of destructive activity in them. If that were so, why should not telangiectatic deformities, naevi, etc., undergo degeneration? The speaker had never seen malignant action or what simulated it in such growths. Mechanical irritation of the parts might be considered one reason for the frequency of these growths and their malignant tissue alterations. But other parts of the body would seem more exposed to irritation than is the face. Moles, and similar growths, are common on other parts of the body as well as on the face, yet in other situations they seem less likely to undergo destructive pathological changes. The field electively most inimical to the presence of these growths, and destructive activity in them when already present, is a quadrangle just taking in the lower lip, the corners of the mouth, extending back to the ears of both sides and extending upward to about an inch above the supraorbital ridge. Of the space thus included, the vicinity of the eyelids and bridge of the nose, was, in the author's experience, the most usual seat of these growths.

The most rational explanation for the frequency of these growths in the situation described, is the nature and abundance of the circulatory nutrition, which must favor hyperplasia. If, however, we accept the above hypothesis, why should these errors of the capillary system, such as naevi, not oftener degenerate? He had frequently operated on these latter deformities, often causing much irritation, but had never seen more than



a slight keloid change result. The speaker then referred to the special danger of malignant degeneration which attends the presence of moles in persons of advanced life.

In regard to treatment, he stated that he had operated on these growths in many ways, and had come to the conclusion that when malignant action is either present or suspected, the combination of Volkmann's curette, followed by the potential cautery, is the most efficient and easiest method of treatment. Of all escharotics, he preferred the liquor hydrargyri nitratis.

DR. I. E. ATKINSON thought that the probable explanation of the frequency of the presence of moles, etc., upon the face as compared with other portions of the body, is that when in this situation patients seek relief, while when covered with the clothing attention is not attracted to them. We should expect that sebaceous new growths would be more commonly seen upon the face, because there we have the greatest activity of the sebaceous apparatus.

DR. JAMES C. WHITE, of Boston, considered that these new formations referred to are not more frequent on the face than on other portions of the body. That they undergo degeneration and form epitheliomatous new formation on the face more frequently than on other parts of the body, he thought, could not be doubted. He had never seen angiomatous formations undergo the so-called malignant change, but they do undergo degenerative processes tending to a spontaneous cure. Formerly he had used the liquor hydrargyri nitratis to a large extent as an escharotic, but within recent years he had substituted the concentrated nitric acid, and the effects obtained seemed to be about the same.

DR. L. N. DENSLOW said that for the past year he had used a solution of one drachm of bichloride of mercury in one ounce of traumatine. Its application is not painful at first and does not excite inflammation for some time. It is particularly useful in the case of children.

DR. R. W. TAYLOR remarked that the author was to be congratulated upon the clear manner in which he had called attention to the danger of these various growths upon the face in a person over forty-five years of age. Such growths are very prone to assume malignant action. In the same connection, it may be remarked that any inflammatory mass about the prepuce, particularly if the result of anterior lesions, should, in old persons, always be ablated.

The Secretary read the

NOTES OF A CASE OF EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA ?), WITH BULLOUS LESIONS,

by DR. W. A. HARDAWAY, of St. Louis, who was unavoidably absent.

The patient, forty-five years of age, stout and somewhat nervous, was seen February 21, 1886. He had always been healthy. The present disease came on Feb. 1st, after a night of fatigue and exposure when heated. The following day a red patch appeared on the pit of the stomach. Others developed, soon running together, leaving no healthy skin between. There was very little scaling at first and no moisture. There was some degree of pruritus. When seen by the author the chest, arms, back, and thighs presented the usual appearances of pityriasis rubra. There was no moisture,

crusts, or appreciable infiltration. The skin was shining and of a violaceous hue. In the morning a handful of scales could be gathered from the sheet, but they were not as large as usual and were inclined to be furfuraceous. The face was not involved. Three or four days after the first visit, there appeared upon the thighs, abdomen, and buttocks a number of tense bullæ. Their appearance was preceded by a distinct chill and followed by a moderate elevation of temperature. The blisters did not run into each other. The bullæ appeared in successive crops of not more than a dozen, each crop being preceded by a chill. Quinine was freely administered and at the end of a week the bullæ ceased to appear. Dr. Hardaway was obliged to discontinue his visits at this period of the case, but the patient gradually improved.

The writer thought that this and other cases which he had seen showed that diseases usually supposed to run a dry course, may under certain circumstances be complicated with lesions containing fluid.

DR. G. H. TILDEN, of Boston, reported

A CASE OF PROBABLE TUBERCULOSIS OF THE SKIN.

A healthy-looking boy of two years of age was first seen in July, 1885. There were six or eight cutaneous lesions scattered over various parts of the body. These were about the size of a split pea, slightly elevated above the level of the skin of a bright red color, which disappeared entirely on pressure. These nodules were hard to the touch with borders of sensible infiltration. They had appeared within the previous five months and had been very slow in growth. During the previous three months there had been failure in appetite and strength, and the child showed an indisposition to walk. He was under observation for three months, during which time one or two fresh nodules appeared. In nearly all the older ones, there ensued softening with formation of pus, which discharged and was followed by cicatrization. About two weeks after the first visit a fluctuating swelling the size of a hen's egg made its appearance on the inner side of the left thigh over the knee-joint, but not communicating with it; this was opened and pus discharged. It healed within a week. The general health became visibly affected. In November there appeared in the left buttock a swelling which gave an obscure sense of fluctuation. In the proximal phalanx of one finger there appeared a pyiform enlargement resembling that seen in dactylitis syphilitica. The child was again seen in February. The swelling in the buttock had increased in size and there was more fluctuation in it. There was at this time, sufficient outward curvature of the lumbar vertebrae to justify a diagnosis of Pott's disease. In his remarks with reference to the case, the speaker said that in the outset the diagnosis of the nature of the cutaneous lesion had been impossible, but from the subsequent course of the disease he thought the most probable diagnosis to be tuberculosis of an unusual form.

DR. L. N. DENSLOW made a supplementary report with reference to

THE TREATMENT OF ACNE BY THE USE OF SOUNDS.

At the last meeting he had reported five cases in which this plan of treatment had been of value. Four of these cases were adults, and all had remained well.

The fifth case was that of a boy about fourteen years of age, and in this case relapse had occurred.

DR. S. SHERWELL, of Brooklyn, stated that he had treated three cases of acne with the use of sounds, and believed that it was useful. He employed this method as an adjunct to other treatment.

A communication with reference to the organization of A CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS was received and the following committee of conference, to report at the next meeting of the Association, was appointed: Drs. H. G. Piffard, of New York; F. B. Greenough, of Boston; R. B. Morison, of Baltimore; G. H. Tilden, of Boston; and Le Grand N. Denslow, of St. Paul.

The following were elected

#### OFFICERS FOR THE ENSUING YEAR:

*President.*—Dr. H. G. Piffard, of New York.

*Vice-Presidents.*—Drs. F. B. Greenough, of Boston, R. B. Morison, of Baltimore.

*Secretary.*—Dr. G. H. Tilden, of Boston.

*Treasurer.*—Dr. Le Grand N. Denslow, of St. Paul.

The Association then adjourned, to meet at the call of the Council.

### CANADIAN MEDICAL ASSOCIATION.

*Eighteenth Annual Meeting, held at Quebec,  
August 18 and 19, 1886.*

#### MEDICAL SECTION.

WEDNESDAY, AUGUST 18.—FIRST DAY.

DR. CANNIFF, OF TORONTO, IN THE CHAIR.

DR. DANIEL CLARKE, of Toronto, read an able paper upon

#### THE MEDICAL JURISPRUDENCE OF CRIME AND RESPONSIBILITY.

The following were the conclusions arrived at:

1st, the natural history of crime shows that brains of chronic criminals deviate from the normal type and approach those of the lower creation.

2d, that many such are as impotent to restrain themselves from crime as the insane.

3d, that immoral sense may be hidden from expediency by the cunning seen even in the brutes, until evoked by circumstances.

4th, no man can shake himself free from the physical surroundings in which he is encased.

5th, crime is an ethical subject of study outside of its penal relations.

6th, insanity and responsibility may coexist.

7th, some insane can make competent wills, because rational.

8th, the monomaniac may be responsible should he do acts not in the line of his delusion, which are not influenced thereby.

9th, many insane are influenced in their conduct by hopes of reward or fear of punishment in the same way as the sane; the rudiments of free will remain.

10th, many insane have correct ideas in respect to right and wrong, both in the abstract and concrete.

11th, many insane have power to withstand being influenced even by their delusions.

DR. SHERMAN, of Ogdensburg, spoke very highly of

Dr. Clarke's paper. He himself, it so happens, is often called into court in cases of crime, or to give evidence as to the validity of a will when the sanity of the testator is under dispute. He observes that the views expressed by Dr. Clarke upon these difficult questions coincide most closely with those which his own observation has led him to adopt.

DR. HOWARD thought the general principles laid down by the reader of the paper could not be made the subject of discussion, for upon them the profession was entirely agreed. These principles and the reasoning upon which they were founded had been ably set forth by Dr. Clarke. It was a matter for regret that the members of the legal profession could not be induced to see the matter in the same light.

DR. SULLIVAN was afraid that many alienists still thought differently from Dr. Clarke, but he was glad to find that this Association was so unanimous in holding such advanced views upon the important matter of criminal responsibility. Dr. Clarke has shown us the difficulties that lie in the way of making a diagnosis in cases of mental disease, but he has failed to point out the remedy. The difficulties are even greater than in organic disease, and younger men would seem to require that experts should lay down some definite rules for them. It is, indeed, a question whether the ordinary practitioner can, or should ever be requested to give an opinion as to the responsibility of a doubtful individual. He has himself once given an opinion as to the entire sanity of a man who, shortly after, proved to be quite out of his mind, and who, indeed, subsequently was the author of the tragedy which ended the life of the lamented Dr. Metcalfe, of Kingston. The alienists themselves still differed much, and much was required to bring them into line, when it was possible for a well-known superintendent to say, as had occurred recently, that in his asylum all the males were mad through masturbation, and all the females through criminal abortion.

DR. CLARKE remarked that no man should hastily decide an obscure case of insanity—*i. e.*, after one or two hasty interviews. Some forms of insanity can be easily diagnosed by the general practitioner, such as dementia, melancholia with delusions, and acute mania; but in cases of delusional insanity, care should be taken not to draw conclusions too rapidly. If the truth is to be arrived at, the specialist giving evidence should not be upon any side, but should be placed in a strictly independent position. Advanced students now in Toronto have the advantage of practically studying mental disease in the asylum, where Dr. Clarke also gives practical lectures. Those instructed in this way can back up their opinions upon good pathological grounds. A definition of insanity can never be given. The old legal ground of a capacity to distinguish right from wrong has done untold harm. The only means he knows of by which an opinion can be arrived at is to institute a comparison between the man as he is and his former self, the idea of which is to be obtained by a careful investigation into his past history, habits, etc.

DR. HOWARD would not be understood to say that the profession was entirely at one upon all the points alluded to by Dr. Clarke, but merely upon the great general principles, especially the abandonment of the crude test of knowledge of right and wrong. He thought

that in all cases an independent jury of experts should be named—men whose position should be free from any leaning to either side, and whose decision would be final.

DR. DUPUIS, of Kingston, read a paper upon

#### DIABETES MELLITUS.

DR. CAMPBELL said that his attention had been strongly directed to the importance of temporary glycosuria from a case recently coming under his observation. A gentleman who, during the season, partook largely of strawberries and cream, was examined for life insurance, and refused, owing to the presence of a large quantity of sugar in the urine. Dr. Clarke re-examined him a short time after his diet had been changed, and found it entirely free from sugar. Such cases were not so rare as might be thought.

DR. D. CLARKE alluded to the frequent appearance of sugar in the urine just before and during acute accessions of mania in the insane.

DR. GEORGE ROSS said that certain cases of glycosuria—persistent, not temporary, as in Dr. Campbell's cases—required to be carefully distinguished from those of diabetes proper. In the former we might have sugar present in the urine for a great length of time, perhaps for years, and yet the symptoms which characterize true diabetes mellitus not showing themselves at any time. It would seem, therefore, that there are two distinct pathological conditions, in both of which the persistent presence of sugar in the urine may be a factor—in the one case coexistent with average health, and in the other marked by a peculiar set of well-known symptoms. In his most recent work upon diabetes, Dr. Milner Fothergill devotes special chapters to these quite different disorders, remarking at the same time upon the confusion on the subject that still exists in the minds of many medical men. To emphasize this, he relates the history of a case somewhat as follows: A physician in India, examining the urine of a patient, found sugar, desiring to be certain of his tests, he applied the various solutions to the suspected urine and to his own, side by side. To his dismay, he found his own urine loaded with sugar. He had been up to that moment in the most perfect health. Uneasy, he returned to England, and was given a strict anti-diabetic diet. His health failed rapidly. After a time he abandoned all attempts at treatment, and resumed his customary diet and habits in every way, with the result of being soon restored to as complete health as he had enjoyed before. Examples of this kind should teach a lesson to be careful in prognosis, and in estimating the effect of any medicine or other treatment in any given case.

DR. HOLMES alluded to the liability of those who have been temporarily glycosuric from improper diet to become diabetic. Such persons should always be cautioned against continuing the use of such articles of food for fear of serious consequences ensuing. He thinks that those physicians are most successful in these cases who begin early with a strict dietary and persistently enforce it. Has had some experience of bromide of arsenic, and thinks highly of it.

DR. GRAHAM thinks we might throw these cases into three classes—viz., 1st, Temporary glycosuria; 2d, A mild form of diabetes; and 3d, A severe form. In some cases of the last series medicine and diet have no effect

whatever, whilst the milder forms are distinctly amenable to treatment, and are thereby either much prolonged or positively cured. In odd instances a glycosuria will be produced by a certain article of diet, and by that alone; a case of this kind from peaches had come to his knowledge. He thinks bromide of arsenic decidedly beneficial. Whether a coincidence or not, he could not say, but since he had begun the use of this drug all his cases had done well. The last of these he would mention. Two brothers, aged fifteen and twenty-two, were severely injured in the same accident; both became diabetic, all the symptoms, when first seen, being very severe. The urine had now diminished from twelve or fourteen pints to five pints, whilst the specific gravity had fallen from 1.045 to 1.028, and even that high figure was mainly from an excess of urea, because there was only a trace of sugar present.

DR. JENNER, of Picton, Ont., read a paper on

#### ALIMENTATION IN SICKNESS.

He dwelt chiefly upon the growing importance of dietetics in the management of sick people, giving many examples of the results of neglecting this department in favor of medication with drugs. He thought that the Canadian schools, as elsewhere, did not give sufficient attention to systematic teaching of the principles of dietetics to their pupils.

DR. ECCLES had often experienced difficulties in the way of having food suitably prepared for invalids. When he thinks it of special importance, he examines the food himself and gives directions for its preparation. We all rely too much upon medicine and too little upon diet. He thinks it often important to insist more upon the systematic, and perhaps frequent, feeding of patients. Persons who are weak should be allowed to take a light supper. To objectors, he points out that animals mostly feed before sleeping. During digestion there is more blood in the abdominal organs and less in the brain, a condition favoring sleep.

DR. HOWARD expressed himself much gratified at the thoughtfulness which had produced such a paper. It often requires courage, especially on the part of a young practitioner, to tell people that what they require is sunlight, fresh air, and good food, and not medicine.

DR. TRENHOLME hoped that the time is coming when we shall hear much more about diet than in the past.

DR. CAMPBELL maintained that the subject of dietetics was by no means so neglected as the reader would have us believe. He thought that, at the present day, every lecturer upon practice of medicine felt it a duty to lay stress upon the management of diseased conditions by attention to the dietary.

DR. CANNIFF said that in the Toronto schools the subject of sanitary science received considerable attention, and the matter of dietetics also held a prominent part in this course.

DR. PLAYTOR, of Toronto, read a paper on

#### THE VALUE OF MORTUARY AND OTHER HEALTH STATISTICS.

He alluded to the work already done in this direction, especially in Ontario, but showed that nothing had yet been accomplished to procure complete statistics for the Dominion at large. He urged the importance of having the subject of collection of statistics constantly brought before the attention of the general government. He



requested the Association to name a committee for this purpose.

DR. J. E. GRAHAM, of Toronto, then read a paper upon

#### CONTAGIOUS PNEUMONIA.

DR. HOWARD said that after thirty-seven years' practice, and after having given a good deal of attention to the subject, it was beyond his experience to have met with such a series of cases as seemed to imply the existence of contagion. He would therefore conclude that there must be, in reality, two forms of the disease—one contagious and the other non-contagious. He thinks that, when we get such groups of cases as those related by Dr. Graham, in which pneumonia would *seem* to have been contagious, we are dealing with a disorder in some way different from the ordinary form of lobar pneumonia. We cannot say this is ordinary pneumonia which has assumed a contagious character owing to the existence of certain peculiar circumstances. If we consider the inflammation of the lungs arising from putrid emanations, we must admit that it is probably not a simple pneumonia, and that much has yet to be learned concerning its exact nature, differing, as it does, in area and in its course from the latter. These clinical features must be remembered even in the face of the evidence adduced from culture experiments, etc. What do the oldest amongst us say? Have they ever seen a case of pneumonia where they considered it proper to secure isolation or disinfection? In cases suggestive of contagion, the greatest care will have to be exercised in instituting an examination into all possible causes for the occurrence of several consecutive cases apart from an origin by direct communication. It is quite possible that sometimes an entirely different explanation may be arrived at. He remarked that in Dr. Graham's cases the consolidation was patchy. This is quite exceptional in ordinary lobar pneumonia, although frequently seen in septic cases. The relation of this disease, as well as others, to a microscopic organism is as yet by no means positively determined. Culture experiments afford very strong evidence of the bacteria being the real originators of the disease, but there remain still some debatable points which must be overcome before the doctrine can be considered definitely entertained.

DR. GEORGE ROSS said that, although seeing a large number of cases of pneumonia every year, he had not met with any such series of cases as necessarily suggested the association of the latter of these with the first by contagion. He knew of Dr. Wilkins's cases alluded to by the reader of the paper, and admitted that they gave support to the idea of contagion. It seemed to him that the extreme rarity of any such groups of cases tended to preclude the possibility of such a common disorder being contagious. If this arose from special surroundings, was it not singular that with hundreds of such cases passing before us, it should be the lot of only one physician at long intervals to meet with examples of its propagation in this way? What peculiar conditions can we think of which would act in this way? If ever contagious, should not this property be manifested oftener? He would rather be disposed to consider that in these localized outbreaks we are really dealing with an affection differing in some essential way, as yet unknown, from the common lobar pneumonia.

DR. GARDINER, of London, had met with a series in one family which seemed to fall within the category of the contagious. The first patient, aged twenty, contracted pneumonia. The mother suffered from chronic bronchitis. She soon fell ill with the pulmonary inflammation. A third member of the family and a grandchild sleeping in the same room were both prostrated by pneumonia within a few days. The only other possible explanation seemed to be a very strong family tendency acted upon by an exciting condition to which all were equally exposed.

DR. FOSTER, of Portland, Me., said that in 1872 they had an epidemic of pneumonia in Portland. A singular feature which he had observed in these cases was that in nine out of ten cases the consolidation affected the apex of the left lung. In about one month they had probably fifty such cases. The course of the disease was unlike ordinary pneumonia, and also unlike typhoid fever. In one locality twenty cases occurred. As Medical Health Officer, he was called upon to investigate the occurrence. On tasting the water supplied there, he found a disagreeable flavor, reminding one of clam-water. He found that this water was supplied to the greater part of the infected district and came from a deep well, being clear and cold. About ten rods above the well were a row of privies,—a main sewer leading from these was traced, and found to have burst and caused the entire soil intervening between it and the well to have become infiltrated with foul matters. The sanitary defects were immediately remedied, the use of the water forbidden, and the outbreak at once ceased. Another endemic he had witnessed also bore upon this discussion. A young boy died of pneumonia in the almshouse after an illness of only two days. Within forty-eight hours they had thirty cases, the consolidation involving either the whole lung or spots in the lung. He found that extensive repairs had been made in the sewerage and pipe-system of the establishment and to this he attributed the outbreak. The cases were treated by an emeto-cathartic at the outset, followed by iron and quinine, and no more cases were lost. He looked upon cases of this kind as being of the nature of some peculiar lung disorder, resulting from blood-poisoning. He has been thirty years in practice and has never seen a case of pneumonia which he had even suspected of being originated by contagion. During the outbreak he had noticed that the nurses and attendants were never attacked.

DR. CASSIDY, of Toronto, remarked that the true etiology of pneumonia is still very obscure. It occurs alike in the houses of the rich and in the poorest hovels. Wherever contagion is thought of we must beware of coincidence which may mislead oftener than we think. The general causes predisposing to pneumonia are of great importance to the sanitarian, because they are remediable. It has been observed in armies that the men in the barracks have sometimes suffered a large mortality from pneumonia, whilst those in the open air have entirely, or almost entirely, escaped, and when removing from close barracks to open tents, the disease had completely ceased.

DR. GRAHAM, in reply, said that the patchy character of the consolidation did not apply in his first case. He would admit in his series a difference of type, but no pathological difference. The doctrine of the unity of

pneumonia receives strong support. Sternberg has found the same parasite in normal saliva as in malignant erysipelas and in pneumonia. If so, the disease is determined not so much by the parasite as by the soil in which it grows. Dr. Graham would still look upon all the pneumonic cases as belonging to the same disease—the first case of a series being an ordinary pneumonia, other cases following it simply because the *materies morbi* finds unusually suitable soil in which to propagate and increase. Those who have experience with the work of developing cultures in the laboratory know that it is a very difficult matter to find a soil upon which certain bacteria will grow at all. An example of this might be given in the microorganism of chloasma, the microsporon furfur. Dr. Klein searched a long time for a congenial soil, all the commonly employed substances turning out failures. Many bacteria also permit of only a very narrow range of temperature. If this vary within 5° F. they die. The question, "What is the cause of ordinary pneumonia?" yet remains unanswered. A predisposing condition of the system is no doubt necessary. In Dr. Foster's cases, the polluted water may have so disturbed the system of those using it as to play the part of a predisposing cause.

DR. J. H. GARDINER, of London, then read a paper on

#### THE INHIBITION OF THE HEART IN DIPHTHERIA.

The striking features of the cases related were the marked slowing of the pulse, followed, in two instances, by fatal syncope.

DR. GRAHAM had no doubt that the heart failure here was due to a poison acting upon the nervous centres. Recent discoveries pointed to the development of poisonous substances in ways not yet thought of, as, *e. g.*, in normal urine, and in the formation of ptomaines. In diphtheria, poisons may form and be absorbed. It is quite possible that even in tetanus, which was alluded to by the writer as opposed to this view, the same thing might occur. In some way not yet understood, a peculiar chemical substance might be produced, having an attraction for the spinal cord, and acting as an irritant upon it.

DR. GEORGE ROSS said that the theory last mentioned seemed the one best calculated to explain the occurrences. He would, however, caution against always attributing a sudden syncope after diphtheria to a central impression. When preceded by inhibitory symptoms, as in Dr. Gardiner's cases, there appeared no reason to doubt this explanation, but he had met with sudden fatality during the convalescence from this disease, where the autopsy showed clearly that the destructive change consisted in extreme fatty degeneration of the heart. Here there had, however, been no symptoms whatever, the pulse remaining at the normal rate. The possible existence of this structural change was another reason why every precaution should be taken during the period of convalescence.

THURSDAY, AUGUST 19.—SECOND DAY.

DR. F. W. CAMPBELL read a paper on

#### THE TREATMENT OF WHOOPING-COUGH BY QUININE.

He spoke of the unsatisfactory character of the treatment usually adopted, and stated that a severe case of the disease in his own family had specially directed his

attention to it. He referred to a paper by Dr. Dawson, Professor of Diseases of Children in the University of New York, on the quinine treatment of whooping-cough, which appeared in the *Canada Medical Record* for July, 1873, also to one by Professor Binz, of the University of Bonn, on the same subject, which was published in 1870. The authors of these papers considered pertussis as a neurosis of the pneumogastric nerve, caused by irritating and infectious mucus that accumulates in the pharynx and larynx. In this mucus was found a fungus, on which quinine had a specific action. Quinine also increased the secretion from the buccal and salivary glands, and thus assisted very materially in loosening the tenacious mucus from the pharynx. Dr. Campbell stated that in his hands the quinine treatment had been most successful, and that he now had notes of over one hundred cases of this disease treated in this way, with most satisfactory results. For children of three years and under, he gave it in doses of half a grain every two or three hours, and proportionately in larger doses up to twelve years of age, when two grains might be given. It should be administered in solution, and *no* sweetening should be added to disguise the taste.

DR. SHERMAN, of Ogdensburg, New York, said he had used quinine in whooping-cough with excellent results. He considered it the very best treatment. He had, however, used sweetening to disguise the taste, and judging from results, saw no objection to it.

DR. MACFARLANE, of Toronto, said he had seen an article by Dr. Campbell on this subject a few years ago. Since then he had used quinine in pertussis, and had had excellent results.

DR. GRAHAM, of Toronto, had employed quinine extensively in pertussis, and could endorse most heartily Dr. Campbell's good opinion of it. Sometimes he had combined it with tannin. So far as his experience went, he saw no objection to the sweetening of the quinine mixture.

DR. CAMPBELL, in reply, stated that Dr. Dawson very strongly objected to any disguising of the bitter taste of the quinine. He had followed the directions in this respect, and was satisfied that they were correct. In fact, he was strongly of the opinion that even the appetizing effect of quinine is much interfered with by the addition of any syrup.

Adjourned.

## CORRESPONDENCE.

### GYNECOLOGICAL OPERATORS IN GERMANY.

THE great rapidity with which pelvic surgery has advanced within the past few years, and the very varying successes of different operators, have tended to develop marked individual traits, and, in a large measure, to accumulate much of the material in the hands of a certain few men. In no country are there to be found, at the present date, so many well-trained scientific gynecologists as in Germany, and it is to the writer a very pleasant task to record some of the experiences which he has had, owing to the courtesies of three of the leading operators in that land. Through the extreme kindness of Dr. M. Säger, of Leipzig, and the courteous attention extended to the writer by Prof. Carl Schröder and Dr. A. Martin, of Berlin, every possible facility for following their work was afforded.

It is hardly necessary to remark that Schröder, Martin, and Säger are men of genius, and that every movement of theirs in connection with their work has a definite purpose, and a fitness peculiarly pleasing to the trained gynecological eye. The methods of Professor Schröder and Dr. Säger are in most respects similar, and are characterized throughout by extreme care and attention to details, by deliberation in operating, by fertility of expediency, and a quiet certainty, inspiring universal confidence in the extent of their resources.

A brief description of Prof. Schröder's work will, then, to all practical purposes, describe that of Dr. Säger. Upon requesting an invitation to the Frauenklinik, a card is given to the visitor, with printed conditions of his visits: That he shall not have seen any contagious cases, or come into contact with any infectious material within forty-eight hours; that he shall bathe, and come to the operating-room in clean linen. Ten or fifteen spectators are usually present, besides five assistants. The visitors are usually notified of the operation by postal card the day before, and at seven or eight o'clock in the morning the operation begins.

The Frauenklinik is situated in the heart of Berlin, on the banks of the Spree, and is, like many other medical and scientific institutions under imperial patronage, palatial in all its appointments. Among the visitors assembled in the waiting-room on the first floor are to be found doctors from the East and West of America: an active bright surgeon connected with the St. Louis Polyclinic; two of our brightest female practitioners in the East, who have bravely fought down every obstacle in their determination to see good work; doctors from the schools in France and Italy, from Chili, Japan, Holland, and from other parts of Germany; Dr. Küstner, of Moscow, a pupil of Pirogoff, and the translator of the Russian edition of Sims's *Uterine Surgery*; and Dr. Muchertschiansk, of Tiflis, in Georgia, well known through his valuable contributions to the *Wiener medicinische Wochenschrift*. The latter had been the assistant to Martin, the father, fifteen years before. The operating-room is on the second floor, well lighted from the whole western side, with painted walls, a very high ceiling, and a smooth stucco floor. A row of stationary stone washstands on one side of the room, and a long table holding solutions of bichloride and carbolic acid, bandages, iodoform, and dishes complete the furniture.

The patient lies on an iron frame table, the assistant dropping chloroform on a small flannel cap covering mouth and nose, while another usually has his hand on the pulse. Professor Schröder is at the patient's left side, while Dr. Hofmeier, usually his immediate assistant, and already well known by his writings, stands opposite, ready to sponge, control the abdominal walls, and render such other aid as may be required.

Consistent with the present status of antiseptic surgery, and bacteriological science in Germany—that is, with the positive convictions of the German surgeons that pyæmia, erysipelas, septicæmia, and probably all forms of suppuration, even the simplest, result from the intrusion of organic impurities upon the field of operation, and the development there of certain specific, more or less toxic properties—in consistency with this view, the most elaborate and important measures have all been taken *before* the operation has begun, and the

keynote to the whole may be found included in the instructions to visitors—the intention is *not so much to war with germs during the operation, as to perform an operation upon a field where no germs are present*. Under these conditions, then, weaker germicidal solutions are used during the operation, solutions which, while powerless to destroy virulent germs in any numbers, yet destroy the few, and have been shown to exert a checking action upon their growth.

A strong spray has been playing for hours in the room; clothing, instruments, hands, and sponges have been thoroughly disinfected (heat is a favorite method for disinfecting instruments); the patient has had repeated baths; and now, just before operating, Dr. Hofmeier, with a large sponge and soap, most thoroughly washes the abdomen, thighs, and genitals, and follows this with a free douching and a solution of corrosive sublimate, 1:1000. Thus all is clean—"penible" and "pils-rein." The spectators group themselves around the foot of the operating-table, with their backs to the light, and follow Professor Schröder's movements as, with a few rapid strokes, he lays open the abdominal walls down to the peritoneum, and, without stopping to clamp superficial vessels, with a few light touches with the point of the scalpel, or by pinching up and nicking the peritoneum, lays open the abdominal cavity. The grooved director is never used, and a dissection of layers is never attempted.

If the tumor is an ovarian cyst, of but a few pounds in weight, it is turned out whole, and the base quickly tied off and seared; the larger vessels in the stump are again tied separately, and the operation completed in about twenty minutes. If the cyst be large it is freely incised, and emptied by rolling the patient over on her side. The sac is then turned out of the incision and adhesions discovered, cautiously separated, and all bleeding points either cauterized or ligated. There is no fear of using too many of the properly prepared fine silk ligatures. One case presented extensive dense pelvic adhesions, and the writer felt here an especial interest in observing the technique. Although eminent authority has declared that "ovariotomy is now a closed chapter," we may hope that, so long as the leading operators differ so markedly in their methods, and the percentage mortality still ranges in the tens, and, above all, our resources in dealing with the most formidable complication, pelvic adhesions, continue to be limited to enucleation, and the slow, dangerous, and often incomplete process of tearing loose and tying, we may at least hope for a *future appendix* to the chapter. In tying broad surfaces, where many would throw one ligature around the whole, or at most transfix and tie, Professor Schröder used many ligatures, and afterward secured by ligation such large vessels as could be discovered in the stump, such is the extreme care to prevent retraction and hemorrhage.

After a careful but not elaborate or prolonged toilet, the incision is closed by stout silk sutures placed an inch apart, with a superficial skin suture alternating. Iodoform is then powdered freely over the wound, and the dressing completed by a piece of rubber gauze, absorbent cotton, and a bandage.

It is impossible to characterize either Professor Schröder's or Dr. Säger's work by any marked peculiarities. To a trained eye the use of the instruments, the quick



touch, the quiet confidence begotten of experience, speak volumes.

Dr. August Martin, on the other hand, while enjoying a reputation for skill and genius equally great, has strong personal peculiarities connected with every step of his work, which at once impress the most superficial observer.

Although not connected with any public institution for teaching, Dr. Martin forms private classes of instruction every few weeks into which most of those not making flying visits are admitted, and are afforded all the vast clinical facilities of his private hospital, and in addition are thoroughly instructed in minor gynecological operations practised upon Winckel's phantoms, in which actual parts—vulva, anus, and pelvic viscera have been skillfully inserted. Dr. Martin's hour for operating is eleven in the morning or twelve noon, and he invariably waits to perform three or four laparotomies at one sitting. Visitors stay down stairs until called by an assistant, they then file up to a special room, where coat, vest, and suspenders are removed, and they enter the operating-room in their shirt sleeves.

The operating-room is small, dingy, and narrow, smelling powerfully of carbolic acid spray. The patient lies at its further end under the window, supported from buttocks to head on a low galvanized iron table, the anæsthetizer and an assistant at the head; behind these the two fair American doctors, and grouped in a crescent on the patient's left the other spectators. Dr. Orthmann or Dr. Czempin are seated on the left assisting, and opposite is Frau Horn, a personage of more than local repute. Dr. Martin sits on a low wooden stool at the foot of the table and directly in front of the patient, whose legs hang over its edges. Dr. Martin and the assistants wear rubber shoes, and the spectators usually stand on a very wet floor throughout the operations.

No description of Dr. Martin's work would approach completeness without some account of his head nurse—Frau Horn. Originally associated for one or two years with Professor Schröder, she has for many years past identified all her interests with Dr. Martin. She is a woman of about middle age, stout, very quick, and with a bright, pleasant face. She makes every preparation for the operations, often takes entire charge of difficult cases in Dr. Martin's absence, and at an operation lends an assistance equal to any I have ever seen at the hands of the best trained hospital resident. She always anticipates the surgeon's wants, and he finds knife, scissors, or needle-holder in his hand without the delay of asking for them. She takes an intelligent interest in every step of the operation, which, in view of the valuable assistance she is rendering, is not obtrusive. She possesses, in fact, all the qualifications so desirable in a chief nurse, a woman all but a surgeon, yet content to remain a nurse. Her notions of absolute cleanliness are as rigid as those of Dr. Martin himself. On one occasion, during my stay in Berlin, a restless patient ruptured the stitches in the abdominal wound in the night and the bowel protruded. Frau Horn carefully cleansed and returned the intestine, reintroduced the stitches and redressed the wound.

She invented both operating and examining tables used by Dr. Martin, as well as the two curious instruments which he figures in his book, and uses in anterior colporrhaphy and perinæauxesis—the broad-ended knife and the comb.

The same careful preliminaries are observed here as at the Frauenklinik. Dr. Martin begins his work seated between the patient's thighs, and holding his knife like a pen, opens down to the peritoneum with a few bold sweeping strokes, and nicking this and slitting it up on the finger, within a minute the abdomen is open, the hand introduced and he is grasping the tumor. If the tumor be of a simple nature, it is quickly rolled out and the operation completed. The visitors then retire to await the next summons, and often another, and still another.

Frau Horn says "Dr. Martin is a true artist in his work," and, indeed, in his use of the knife, and his wonderful skill and certainty in introducing sutures in deep, almost impossible places, and by his general rapidity and assurance, he certainly justifies the assertion. In some cases, which in other hands would prove very tedious or even impossible, his methods are very remarkable, and even at times startling. Tumors fixed in the pelvis by adhesions, impacted myomata, and tubes and ovaries matted in old and recent exudates, are grasped and dragged out with the exercise of great strength, and they often yield with suddenness, producing a great suction sound which is alarming. If the field is in the least impeded by the intestines, they are all turned out and held in a towel, as originally practised by Dr. Martin's father.

In cases of hysterectomy, of which the writer saw a number, the tumor was lifted well up, and the lowest part of the uterus which could be reached firmly grasped by an elastic ligature. Deep lateral ligatures controlled the uterine arteries. The tumor was then shelled out, and the uterus split down to within a short distance of the ligature, the two sides were then amputated so as to leave a funnel-shaped hole in the cervix, which was scraped out, disinfected, and closed by three stages of continued sutures. When completed and dropped, the stump, always intraperitoneal, presented the appearance of a purse puckered across the top, with the line of sutures in the coronal axis of the body. When any considerable bleeding occurred sponges were packed into the pelvis, the operation continued, and the bleeding points caught and tied afterward.

Both Dr. Martin and Professor Schröder opened cases of cancerous disease, in which there was nothing to do but close the incision immediately. The former also opened two cases of tubercular peritonitis which were closed at once. These operations occurring once or twice weekly, it would often be possible to see seven laparotomies in one day, as both operators prefer waiting until there is more than one case to operate upon.

The facilities for seeing surgical, and especially gynecological, work in Berlin are not surpassed, and, I believe, scarcely equalled in any other city in the world.

Beginning with Professor Schröder's operations at seven in the morning, followed always by an admirable practical discourse, which is often replaced by operative midwifery, in the Entbindungs Anstalt, and Professor Bardeleben's clinic at the Charité at ten, and at eleven Dr. Hahn's clinic at the Friederich-Hain, in a room with most perfect equipments, and at eleven or twelve Dr. Martin's operations, in the afternoon. Again, the visitor is always sure of seeing major operations at Professor Bergmann's clinic, at the Königl. Klinikum,

and at five can attend Professor Gusserow's admirable course at the Charité.

The trouble is not in finding occupation but in disposing of an *embarras de richesse*, and for the most advanced scientific work, for facilities, for courtesy, and, for what is not unimportant to many, good and cheap living, my advice is "go to Berlin."

HOWARD A. KELLY.

EDINBURGH, August 2, 1886.

#### POISONING BY CASTOR-OIL BEAN.

To the Editor of THE MEDICAL NEWS,

SIR: It is a fact probably not generally known, even to the profession, that the seeds or beans of the "castor-oil plant" (*ricinus communis*), quite commonly grown in gardens for ornamental purposes, are actively poisonous. The knowledge of the familiar oil expressed from them naturally induces the idea that the beans have similar medicinal properties and are equally harmless, but it is evident from the effects which they produce when taken internally that they contain other much more powerful constituents than the oil. This is true also of the cotton-seed. Cotton-seed oil is a perfectly bland oil, frequently sold as "sweet oil," and now largely exported from New Orleans to Italy, to be thence imported into this country as "fine olive oil." Yet an infusion of the seeds is, I am informed, a popular remedy in the South against intermittents.

Numerous fatal cases of poisoning by castor-oil beans have been reported, and three of them are said, upon good authority, to have caused death in an adult. A serious, though fortunately not fatal case, in which twelve or fourteen of the beans were eaten by a middle-aged woman for the relief of obstinate constipation, occurring recently in my own practice, has led me to ask the use of your columns to call attention to the danger of allowing the beans to be eaten carelessly or ignorantly.

Yours respectfully,

EDWIN H. BIDWELL, M.D.

VINELAND, N. J.

#### NEW INVENTIONS.

##### A NEW SERIES OF BERLIN WOOLS FOR THE SCIENTIFIC DETECTION OF SUB-NORMAL COLOR-PERCEPTION (COLOR-BLINDNESS.)

BY CHARLES A. OLIVER, M.D.,  
ONE OF THE OPHTHALMIC AND AURAL SURGEONS TO ST. MARY'S  
HOSPITAL, PHILADELPHIA, ETC.

BELIEVING that Holmgren's method for the detection of color-blindness is the best, I have devised a new series of loose wools in an endeavor to place his plan upon a more substantial basis. In this set there are three series of colors:

1. Five principal test-skeins. These are pure colors. Latin names are employed to represent them. They are made of equal intensities, and are not designated except by being made of large size.

2. A series of twenty small pure match skeins. Each skein is either a pure tint or a pure shade of one of the large skeins, and has a black bangle containing lettering fastened to it; the inscription indicating that the skein is either a certain tint or shade.

3. A series of seventy-two small confusion match

skeins. Each skein contains a mixture of certain percentages of light and shade of two of the large skeins. Each has a bangle which shows that is of such a character.

The wools are to be wrapped in black muslin, and will be enclosed in a black box, which will also contain an explanatory sheet with the colors arranged in their proper order, together with a book of instructions and a spectacle frame with a movable stop.

In addition to the good qualities possessed by the Holmgren wools, the following special advantages can be claimed for the new system:

1. *Five principal tests.* Pure blue and pure yellow have been added.<sup>1</sup> This has been done because both of these pigments serve as useful tests in the detection of the barely perceptible changes in color-sense which occur in the incipient stages of optic nerve disease.

2. *The wools are loose and separate.* By this the candidate has the entire mass of color from which to select, and there is nothing by which judgment as to plan can be brought into play.

3. *The colors are all of equal relative intensity.* This makes the selection a question of color choice alone; any interference to accuracy being avoided by keeping free from the power of skilful shading possessed by the "color-blind."

4. *Each skein has its value expressed.* Every skein becomes a unit of worth, and is related to every other skein. This has been done by the selection of colors of relative intensities, and by the use of a system of bangles which is incomprehensible to all but the initiated.

5. *It can be employed by any educated layman.* By means of the bangles the registry of the choice is easy for anyone who has been made acquainted with the method. A report of the selection can be copied upon a printed form, which can be sent to any authoritative person by whom it can be studied, and the color-sense of the examinee properly and fully determined.

6. *Accurate notings of passing color-changes can be preserved for future comparison.* This is of importance in furnishing means by which more accurate study of disease can be made, better notions of prognosis given, and more useful plans of therapeutics applied.

7. *Written and verbal expression of the character and amount of subnormal color-perception can be given.* This will afford the reader of any article or hearer of any paper upon this subject, more exact data in reference to the nature and degree of the color-changes noted. The vague terms now employed can be discontinued, and expressions like those used for the acuity of vision, etc., substituted.

8. *All the wools are of the same grade of manufacture.* This destroys, in measure, any argument against the employment of this material in color-testing, because here the chances for selection, by the use of touch, are greatly lessened.

9. *All the colors are from vegetable dyes.*<sup>2</sup> By this,

<sup>1</sup> The rose (purple) test of this series has more red in it than is found in this sample among Holmgren's wools. This has been done so as to get all of the principal test-skeins of the same degree of saturation and intensity.

<sup>2</sup> Some of the dyes of the present invoice are not vegetable in character, although they have been employed because differentiation by the sense of touch is impossible upon account of the equal

any error that might arise from harshness of color-surface allowing detection by the sense of touch is avoided. Besides, such colors are more lasting to light exposure, and not so subject to the objection of possessing odor.

10. *The use of a black surface in testing.* Here there is nothing but a display of color. Contrast is avoided, and any chance for the formation of subjective after-colors lessened.

11. *Any order of testing may be pursued.* This is done by naming the tests, so that any color may be taken first.

12. *Quantitative determination as well as qualitative determination obtained at one sitting.* This has not been accomplished by any other method.

This series of wools were exhibited at the late meeting of the American Ophthalmological Society. James W. Queen & Co., of Philadelphia, have gone to considerable expense and difficulty in having all of the wools imported from a large European house. Sets will be ready in a short time.

1507 LOCUST STREET.

## NEWS ITEMS.

**THE MANUFACTURE OF QUININE BY SYNTHESIS.**—According to the *Lancet*, a remarkable discovery, by which the price of quinine may be reduced to something like 3d. per ounce, has been made by Mr. Cresswell Hewett. The synthetical manufacture of quinine was first suggested to Mr. Hewett in 1869 by the late Dr. Mattheson, of St. Bartholomew's Hospital, whilst giving his assistance in a course of experiments in connection with apomorphia. Subsequently, Prof. Parkes, of Netley, aided with his advice, and to these gentlemen, rather than to himself, Mr. Hewett modestly explains that the process is due. The importance of this discovery is rendered greater by the fact that while hitherto we have been depending for our quinine on the cultivation of the cinchona tree, from the bark of which only about two per cent. of good quinine can be extracted, ninety-eight per cent. being valueless, the drug can now be manufactured without limit by a very simple process from an article which can always be got in abundance in any part of the world.

**DEATH FROM BROMIDIA.**—A telegram to the Austin *Statesman*, from Waco, Texas, announces the death on July 6th, at the latter place, of Dr. Joseph Willis from an overdose of bromidia, taken for the relief of pain. The *Texas Medical Journal* speaks in very high terms of the deceased, who although only thirty-eight years old, had been for several years a prominent member of the Texas State Medical Association.

**FOOD INSPECTION IN OHIO.**—A law has been enacted in Ohio creating the office of dairy and food commissioner. His duty is to inspect any article—butter, cheese, lard, syrup, sugar, or other articles of food and drink—and to prosecute corporations, firms, or persons engaged in the manufacture or sale of any adulterated

or counterfeit article of food or drink in violation of the laws of Ohio.

**SIR WILLIAM STOKES, OF DUBLIN.**—A Dublin correspondent of *The Lancet* writes: "The numerous friends of the President of the Royal College of Surgeons in Ireland will be gratified to learn that he has received the honor of knighthood at the hands of his Excellency the Lord-Lieutenant. Sir William Stokes is an able exponent of Irish surgery, a gentleman of high professional eminence, and possessed of abilities of no mean order. A clever writer, an eloquent speaker, and an honorable gentleman, Sir William holds a foremost place in professional circles in Dublin. The only regret that can be felt is that the higher dignity was not conferred upon a gentleman who holds the highest position the Fellows of the Royal College of Surgeons could bestow upon him. It cannot be denied that successive Governments have dealt very shabbily with the medical profession in Ireland, and it is to be hoped—although from the past little can be expected—that the new Government may see their way to reward the profession in Ireland as in other portions of the United Kingdom."

**PROF. LANGENBECK** has just undergone an operation for cataract at the hands of Dr. Pagenstecher, and was dismissed from the clinic, perfectly cured, at the end of eleven days.

**PROFESSOR BOUCHARD** has been elected member of the Académie de Médecine.

**A MUNIFICENT GRATUITY.**—A gratuity of £10,000 has been granted from the Bavarian Civil List to the widow of Prof. von Guden, of Munich, who perished with the late King of Bavaria in the lake at Castle Berg. He left a family of eleven children.

**TEA-DRINKERS' DISEASES.**—It is not a little curious that the diseases arising from the wrong use of tea should be met with in greater frequency in countries foreign to its growth. It might have been supposed that where production went on there would be found those evils that attend the consumption of tea in their greatest extent; but such does not appear to be the case. The diseases due to tea are well known to physicians, but the public seem to be strangely indifferent to the teachings of their medical advisers in these matters. Recently in France, M. Eloy has reminded medical men how vast is the number of diseases owing an allegiance to the dominion of Queen Tea. The list of headings in M. Eloy's paper is well calculated to arouse attention, and, we hope, to lead to some abatement of this widespread disorder. America and England are the two countries that are afflicted most with the maladies arising from the excessive consumption of tea. Individuals may suffer in a variety of ways. It is customary to speak of acute, subacute, and chronic "theism"—a form that has no connection with theological matters. It is possible to be a "theic" by profession or a "theic" by passion. The predominance of nervous symptoms is a characteristic of theism; general excitation of the functions of the nervous system may be observed; or the weakness may be noted more especially in the brain as distinguished from the spinal

intensities. In order to avoid any error whatever, attention will be paid to this question in all future selections.

I shall be pleased to assist anyone in obtaining the proper selection of wools, and to give all necessary information in reference to their manufacture.



cord. Perversion of the sense of hearing is not at all an uncommon symptom—patients hearing voices that have no real or objective existence. The irritability that overtakes women so frequently may sometimes be clearly traced to an excessive indulgence in afternoon tea. It is a mistake to suppose that it is the poor sempstress who is the chief sufferer from theism. No doubt the tannin which tea has been standing long contains does a great amount of mischief, but the derangement that it causes hardly belongs to that class of diseases with which we are at present concerned. Rather does theism belong to that genus of disease in which morphinism, caffeism, and vanillism are found. The habit of tea-drinking is one that grows on its victims like the similar ones of opium or alcohol. Taken in strict moderation, and with due precautions in the mode of preparation, tea is, like alcohol, a valuable stimulant; in its abuse there is also a certain analogy. There is hardly a morbid symptom which may not be traceable to tea as its cause. This is a fact that general practitioners often use to their own satisfaction and to their patient's advantage, if it happen to be that kind of patient who does not object to make some sacrifice in order to be rid of troubles.—*Lancet*, July 3, 1886.

**CHOLERA IN JAPAN.**—News comes from Japan that the cholera epidemic there becomes more and more intense. Strangers, and the Japanese in good circumstances, are not suffering much from its attacks, but the poor native population is almost decimated.

**IRREGULAR SCHOOLS.**—The following is a list of colleges, the diplomas of which will not be recognized by the Iowa State Board of Health:

American Eclectic College, Cincinnati; American Health College, Cincinnati; American University of Pennsylvania (Buchanan), Philadelphia; Beach Medical Institute, Indianapolis; Bellevue Medical College of Massachusetts; College of Physicians and Surgeons, Buffalo, N. Y.; College of Physicians and Surgeons, Milwaukee; Eclectic Medical College of Philadelphia; Edinburgh University, Chicago and St. Louis; Excelsior Medical College, Boston; Hygeo-Therapeutic College, Bergen Heights, N. J.; Hygeo-Therapeutic College, New York City; Joplin Medical College, Joplin, Missouri; Livingston University, Haddonfield, N. J.; Medical Department of the American University of Boston, Boston; New England University of Arts and Sciences, Boston; New England University of Arts and Sciences, Manchester, N. H.; Penn Medical University, Philadelphia; Philadelphia University of Medicine and Surgery, Philadelphia; Physio-Eclectic Medical College and Physio-Medical College, Cincinnati; St. Louis Eclectic Medical College, St. Louis; St. Louis Homœopathic Medical College, St. Louis; Curtis Physio-Medical Institute, Marion, Indiana; American Anthropological University of St. Louis; Medical Department of Drake University, Des Moines, Iowa; and King Eclectic Medical College, Des Moines, Iowa.—*Iowa State Medical Reporter*.

**EXAMINATION OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.**—The following questions were submitted to the candidates at the recent final examination for the diploma of Member: *Surgical Anatomy and*

*the Principles and Practice of Surgery.* (Candidates were required to answer at least four (including one of the first two) of the six questions, and were strongly advised to answer all six questions.) 1. Give the relations of the femoral artery in the middle of the thigh, and describe the operation for applying a ligature for punctured wound at that part. 2. Describe the position and attachments of the omohyoid muscle. State fully its relations to the larger vessels of the neck, and its use as a guide to the operator. 3. What is an intussusception of the bowel? Give its causes, diagnosis, and treatment. 4. Give the differential diagnosis of ascites, ovarian tumor, and pregnancy. Describe the operation of ovariectomy. 5. Give the signs of a dislocation of the radius and ulna backward. What structures would resist reduction? How would you reduce the dislocation, and in what position would you put the limb afterward? 6. How would you diagnose an acute inflammation of the middle ear? What are the dangers of such a case? Describe its treatment. *Midwifery and Diseases of Women.* (Candidates were required to answer three of the four questions.) 1. How would you distinguish between a face and breech presenting? Describe the management of labor when the breech presents. 2. How would you treat a case of partial placenta prævia when the os uteri is dilated to the size of half a crown and hemorrhage is present? 3. What is puerperal eclampsia? What are the pathological conditions with which it is associated? How would you treat a case (1) before the attack, (2) during the attack? 4. What is pelvic hæmatocoele? What are the conditions for which it may be mistaken, and how would you make the diagnosis? *Principles and Practice of Medicine.* (Candidates were required to answer three of the four questions, including question No. 4.) 1. What are the causes, symptoms, sequelæ, diagnosis, and treatment of diphtheria when it affects the fauces and pharynx? 2. Describe the causes, appearances, and treatment of ringworm; give the prognosis and diagnosis. 3. What are the different kinds of hemiplegia, and how does each kind enable you to predicate the seat and nature of the lesion? 4. Give the composition, uses, and doses of cerii oxalis; injectio morphiae hypodermica; liquor strychniæ; oleum terebinthinæ; pulvis ipecacuanhæ compositus; pulvis kino compositus; tinctura camphoræ composita; tinctura cannabis indicæ.

**MEDICAL SCHOOL IN TURKEY.**—Turkey has a medical school at Constantinople, at which there are annually more than three hundred students, of which number some sixty are graduated. Each course continues during nine months of the year, and six years must be spent in medical study before a diploma can be received. Instruction is given in the Turkish language, as most of the students are Turks.

**RESPONSIBILITY OF DRUGGISTS.**—A Montreal man lately sued a druggist for damages for having been deprived of work for several weeks in consequence of taking poison sold him by mistake. The error was caused by the wholesaler, who had labelled the package wrongly before selling it to the druggist. The court held, however, that the druggist should have verified the contents of the package, and gave judgment for two hundred dollars and costs.

**A PROFESSIONAL SINECURE.**—It is officially announced that Señor Rafael Alcalde y Buril has been appointed surgeon-dentist to the infant king of Spain, whose birth lately gave rise to so much rejoicing in the Spanish capital. The *Globo* inquires, very naturally, whether the young king was born with teeth. In any case, the post of this professor of the gentle dental art will, for some months to come, be as much a sinecure as that of the surgical instrument-maker who was recently addressed by a country customer as "suspensory bandage-maker to Her Majesty."—*British Medical Journal*.

**DEAF-MUTISM IN SPAIN.**—According to Señor Don J. Lopez Navalon, Principal of the National College for Deaf-mutes in Madrid, the number of persons afflicted with deaf-mutism in Spain is more than 10,000. For these there are, beside the Madrid College, which is supported by the State, only four other institutions in the provinces, and these are all supported and managed by private enterprise.

**CREMATIONS AT PÈRE LA CHAISE.**—Next month the Parisians will be able to burn their dead in four crematory furnaces, which have just been finished at Père la Chaise. These furnaces were begun last November, and have been hurried on to completion, so that by the end of August, at latest, those who, in dying, express the wish to be cremated can be there reduced to ashes. There will be no first, second, and third class cremations. Poor and rich will be on a footing of absolute equality. The price charged to those who can afford to pay for the burning of a corpse will be 15 f.—or say 12 s. The furnaces were constructed on plans by MM. Barrett and Formice. A large portico is in front of a dome, beneath which are placed the crematory furnaces. They have the appearance of very elegant ovens. Three hundred and fifty thousand francs is the price they cost. They are according to the Corini system, in use in Rome and Milan. It was found that the heat of the Siemens furnace was too intense. Instead of reducing the corpse to ashes, it subjected it to a kind of vitrification. The cost, too, would be 200 f., instead of 15 f., to cremate with a Siemens furnace. The unclaimed bodies at the hospitals which are not used for anatomical purposes will be taken to the crematory at Père la Chaise. Sculptors, goldsmiths, and bronze-casters are already busy designing urns, of which an assortment in marble, bronze, gold, silver, zinc, or lead will be kept at an office of the crematory. The relatives of the cremated dead can buy these vessels, and cause them to be removed to family vaults or to a building which the city of Paris is to erect. There could be no greater boon to a large city with overcrowded cemeteries than the furnaces of Père la Chaise. I cannot conceive anything more disrespectful to the dead than the way their remains are treated here, even when a first-class burial can be provided, if there is not a family vault in which to place them. Buying a grave is no simple matter. The delays are endless, and the application for one must go through many bureaus before official consent is given. Then there are other formalities to be gone through. Meanwhile the corpse is in a charnel house, called a provisional vault, at a cost of 1 f. a day. The removal thence to the grave, which must be in masonry at the sides, is a cause of danger to the public health.—*London Daily News*.

**THE VATICAN AND CREMATION.**—The Roman Holy Office has issued a decree forbidding Roman Catholics to belong to cremation societies, and the practice of cremation is stigmatized as *detestabilem abusum corpora humani cremandi*.

**HEIGHT AND WEIGHT.**—Dr. Broca, the eminent anthropologist, is the author of a formula relative to the height and weight of the human body. It is that the body should weigh as many kilogrammes as it measures in centimetres, after deduction of the first metre. Thus, a man measuring one metre eighty centimetres should weigh eighty kilos. Should his weight be more or less, he is too stout or too thin. As men grow older they lose weight, but as a compensation they diminish in height also.

**INDESTRUCTIBILITY OF HUMAN HAIR.**—That human hair retains its characteristics for long periods of time, and, indeed, is well-nigh indestructible, is a fact of common observation. A remarkable instance of this is found in a wig which has recently been discovered in an Egyptian temple at Thebes, and is now deposited in the British Museum. It is supposed to have been part of the attire of an Egyptian priest, and from the circumstances of its discovery is regarded as being at least 3400 years old.

**A PAIR OF CENTENARIANS.**—There has recently died in St. Petersburg Madame Goruli, a contemporary of the Empress Catherine II., and a lady of the court of the Emperor Paul I. She is stated to have been 114 years old. Among those who attended her funeral was her sister, who had attained the age of 113, but who was still so robust as to be able to follow the bier on foot.

**APPARENT INTOXICATION.**—There is reason to fear, says the *Lancet*, that mistakes are not unfrequently made, even by skilled observers, in the recognition of drunkenness, by what may be called "apparent intoxication." The unsteady gait, the congested face and neck, the vacant eye, with drooping lid, and even the spiritous breath of apparent intoxication, may one and all be the effects of disease or disturbance of function, which has no necessary connection with the abuse of alcohol in any form. A melancholy instance of blundering in respect to this matter may be cited from the life of the late Colonel Herbing, who, as our Paris correspondent mentioned last week, was accused of intemperance during his field service at Tonquin, but happily acquitted. Professor Peter, who had opportunities of studying the case of this recently deceased officer shortly before his death, elicited that he was suffering from a malady of some years' standing, which produced cerebral anæmia with such giddiness that he could scarcely sit on his horse. Similar cases are by no means uncommon, and while it is more than ever necessary to denounce the practice of permitting police officers to determine whether a man or woman is drunk or the victim of disease, it is requisite to go much further than this, and to call the special attention of skilled practitioners in medicine to the possibility of being mistaken by erroneous impressions on this subject. Not only will anæmia of the brain, however induced, cause giddiness, but certain forms of defective assimilation

will bring about the same results, together with symptoms still more deceptive. We need to study more closely the effects of an excess of oxalic acid in the blood, of accumulated uric acid, or urate of ammonium, of acetone, etc. Something has been done in this direction; but, so far as we are aware, the precise cause of a peculiarly offensive odor of the breath, expelled from the mouth, seemingly distinctly alcoholic, has not been satisfactorily made out, although several good clinical observers with a fair knowledge of the chemistry of digestion and elimination have undertaken to solve the problem. It would be useful to investigate the subject further; more light is desirable, and even necessary.

**PRIORITY IN THE USE OF POTASSIUM IODIDE IN ANEURISM.**—Duroziem points out, in *l'Union Médicale*, 1886, No. 44, that the credit for priority in using potassium iodide in aneurism is not due either to Chuckerbutty or to Balfour, as generally stated, but to Bouillaud. This observer published in the *Gazette des Hôpitaux*, for February 8, 1859, a paper entitled "Two cases of aneurism treated by iodide of potassium; gradual and complete disappearance of one, decided improvement in the other."

**NECROPTIC ENTOMOLOGY.**—In a discussion of medico-legal subjects at a recent meeting of the Académie de Médecine, M. Laboulbène said that entomology ought to render great service in tracing the probable length of time that a body had been dead. The *insectes nécrophiles*, or carrion insects of the earlier decomposition, leave their prey in a regular order of succession. There comes a time, however, when the dry horny portions alone are left, and even these are attacked by the attagenes, anthrenes, and ptiolioses, etc. in a certain definite order.

**DR. CHARLES D. HOMANS**, of Boston, died at Bar Harbor, on the evening of Thursday, September 2d. Dr. Homans was born in Brookfield in 1826, and was educated at Harvard College, receiving his degree of B.A. in 1846, and of M.D. in 1849. His father, Dr. John Homans, was a noted physician in his time, and his grandfather was a surgeon at the battle of Bunker Hill. He was a member of the first surgical staff of the Boston City Hospital, and at the time of his death was the senior visiting surgeon to the institution. He was President of the Massachusetts Medical Society for two years, resigning only a few weeks ago, and at the time of his death he was President of the Massachusetts Humane Society.

**DR. THOMAS A. MCBRIDE**, of New York, died at sea on board of the North German Lloyd Steamship "Aller" on Tuesday, August 31st, aged forty years. He had been at Karlsbad during the summer for the benefit of his health, and seemed greatly improved until a few days previous to his departure from London, where he was taken ill. He recovered sufficiently to enable him to proceed to Southampton where he was able to board the "Aller." On the steamer everything possible was done for him by Captain Hammelman and Surgeon Norr, assisted by Dr. D. B. St. John Roosa, of New York, who was a fellow passenger. It was evident, however, by the following afternoon that he was conscious of his approaching death. After bidding good-bye to

some friends who were with him, he relapsed into semi-consciousness, from which he did not rally. He was buried at sea at midnight on Tuesday. Dr. McBride was attending physician to the Presbyterian Hospital, and a well-known specialist in diseases of the nervous system.

#### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM AUGUST 31 TO SEPTEMBER 6, 1886.

**MIDDLETON, P.**, *Major and Surgeon*.—Assigned to duty at St. Francis Barracks, St. Augustine, Fla., as Post-Surgeon.—S. O. 126, *Division of the Atlantic*, September 2, 1886.

**LA GARDE, L. A.**, *Captain and Assistant Surgeon*.—Upon departure of Third Infantry from Fort Ellis, Montana Territory, to proceed to Camp Sheridan, Mammoth Hot Springs, Wyoming Territory, and report to the commanding officer for duty, relieving Assistant Surgeon Pilcher.—S. O. 87, *Department of Dakota*, August 27, 1886.

**CRAMPTON, L. W.**, *Captain and Assistant Surgeon*.—Relieved from further duty at Bellevue Rifle Range, and granted leave of absence for one month, to take effect before rejoining his proper station (Fort Bridger, Wyoming).—S. O. 108, *Department of the Platte*, August 28, 1886.

**PILCHER, JAMES E.**, *First Lieutenant and Assistant Surgeon*.—When relieved by Assistant Surgeon La Garde, from duty at Camp Sheridan, to return to his proper station (Fort Custer, Montana Territory).—S. O. 87, *Department of Dakota*, August 27, 1886.

**WOOD, L.**, *First Lieutenant and Assistant Surgeon* (recently appointed).—Ordered to report by letter to the Commanding General of the Department of Arizona, for assignment to duty.—S. O. 202, *A. G. O.*, August 31, 1886.

**MASON, CHAS. F.**, *First Lieutenant and Assistant Surgeon*.—Relieved from duty in the Department of the East and assigned to duty in the Department of Arizona.—S. O. 203, *A. G. O.*, September 1, 1886.

**WALKER, FREEMAN V.**, *First Lieutenant and Assistant Surgeon* (recently appointed).—To report in person to the Commanding General, Department of the East, for assignment to duty.—S. O. 203, *c. s.*, *A. G. O.*

#### OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY, FOR THE WEEK ENDING SEPTEMBER 8, 1886.

**DICKSON, S. H.**, *Passed Assistant Surgeon*.—Detached from the Naval Academy, October 1, 1886, and ordered to Navy Yard, Washington.

**LIPPINCOTT, J. G.**, *Passed Assistant Surgeon*.—Ordered to Naval Academy, October 1, 1886.

**SHIPPEN, E.**, *Medical Director*.—Detached from Naval Hospital, Philadelphia, Pa., and ordered to attend officers of the Navy and Marine Corps at Philadelphia not otherwise provided with medical aid.

**HORD, WM. T.**, *Medical Director*.—Detached from Examining and Retiring Boards at Washington, October 5th, and ordered to Naval Hospital, Philadelphia, Pa.

**DEAN, R. C.**, *Medical Director*.—Ordered to duty as a member of Examining and Retiring Boards at Washington, October 5, 1886.

**BRANSFORD, J. F.**, *Surgeon*.—Detached from U. S. S. "Ironquios," and ordered to Naval Hospital, New York.

**HALL, C. H. H.**, *Passed Assistant Surgeon*.—Detached from Naval Hospital, New York, and ordered to Naval Hospital, Yokohama, per steamer of 21st inst.

#### OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, FOR THE THREE WEEKS ENDING SEPTEMBER 4, 1886.

**BAILHACHE, P. H.**, *Surgeon*.—To proceed to Cape Charles Quarantine, as Inspector, August 27, 1886.

**FESSENDEN, C. S. D.**, *Surgeon*.—Granted leave of absence for thirty days, August 30, 1886.

**GODFREY, JOHN**, *Surgeon*.—To proceed to Biloxi, Mississippi, and investigate alleged yellow fever cases, September 1, 1886.

**IRWIN, FAIRFAX**, *Passed Assistant Surgeon*.—Granted leave of absence for thirty days, September 2, 1886.